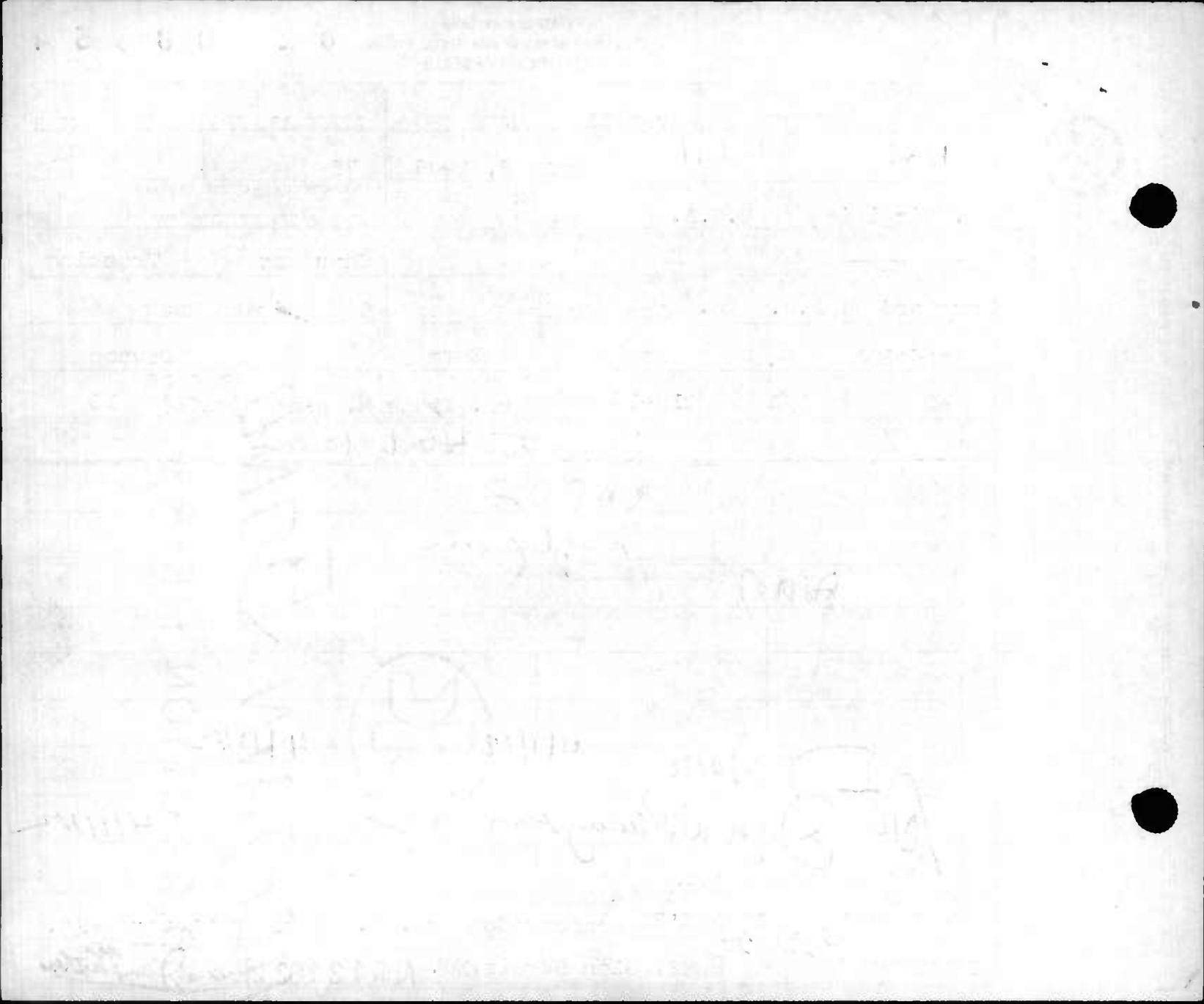


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 6208354 EST		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR		
LAWRENCE			RUSSELL		ASHBY	APRIL 10, 1982				12:40 PM		
3. SEX		4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS						
Male		White	July 6, 1906			75 YRS IF UNDER 24 HRS HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
W. Virginia		U.S.A.										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
GLEN BURNIE		NORTH ARUNDEL HOSPITAL			Chauffer		Trucking					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE Maryland		13b. COUNTY A.A. Co.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 904 Andrews Road				
14. FATHER'S NAME FIRST Randolph		MIDDLE M.		LAST Ashby		15. MOTHER'S MAIDEN NAME FIRST Emma		MIDDLE LAST Dawson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. NOVA			17. INFORMANT		ADDRESS Same as #13 Mrs. Irene M. Ashby (wife)					
18 CAUSE OF DEATH (Enter only one cause per line for (a) and (b)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> 4920 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (c). <i>4920 - Hypertension</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/9/82, 19_____, to 4/11/82, 19_____, that (I) (we) last saw the deceased alive on 4/9/82, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.										4/11/82		
22b. SIGNATURE <i>Jorge B. Ramirez, M.D.</i>		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		DATE SIGNED 4/11/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JORGE B. RAMIREZ, M.D.		22e. ADDRESS 7845 OAKWOOD ROAD, #205 GLEN BURNIE, MARYLAND 21061										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 13 APR '82		23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Mem. Pk.			23d. LOCATION CITY OR TOWN Elkridge		COUNTY Howard		STATE Md.	
24. FUNERAL DIRECTOR NAME SINGLETON		ADDRESS FUNERAL HOME, Glen Burnie, Md.			25a. DATE REC'D. BY REGISTRAR APR 12 1982		25b. REGISTRATION NUMBER <i>James Van Winkle</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the Funeral Director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 shows only injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8208355				
												REG. NO.				
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
			HENRY (NMN)			BARTON, Jr.			4	4-6-82		552 M				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Male			Caucasian			/ 9 97			85							
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			Anne Arundel MD.				
RI			USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Anne Arundel							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Annapolis			Anne Arundel General Hospital			Rel Executive			Standard Oil							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
MD			AA			Annapolis			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			130 Southgate Avenue			21401	
14. FATHER'S NAME FIRST			LAST			15. MOTHER'S MAIDEN NAME FIRST			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS	
Henry			Barton Sr			Ammie			219-30-8656			Ethel Barton			Spooner	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN			(IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			16c. ADDRESS			16d. INFORMANT			16e. APPROXIMATE POSITION BETWEEN CITY AND DEATH	
Yes			WWI												Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for items (a), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)															18f. APPROXIMATE POSITION BETWEEN CITY AND DEATH	
<i>Cancer</i>															<i>Terminal</i>	
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															18g. APPROXIMATE POSITION BETWEEN CITY AND DEATH	
(b) <i>Myocardial infarction</i>																
(c) DUE TO, OR AS A CONSEQUENCE OF																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			21d. LOCATION STREET			CITY OR TOWN		COUNTY STATE		
21e. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21g. DEGREE			21h. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			21i. DATE SIGNED				
22a. I certify that (I) (the hospital) attended the deceased from 3/19/82 , to 4/6/82 , that (I) (we) last saw the deceased alive on 4/6/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			22b. SIGNATURE <i>R. I. Hochman, M.D.</i>			22c. ADDRESS <i>16 Murray Ave, Annapolis, Md 21401</i>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>4/7/82</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE April 7, 1982			23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln			23d. LOCATION CITY OR TOWN Brentwood			23e. COUNTY P.G.		STATE MD		
24. FUNERAL DIRECTOR NAME <i>John M. Taylor & Sons - Annapolis, MD</i>			25a. ADDRESS <i>Annapolis, MD</i>			25b. DATE REC'D. BY REGISTRAR APR 12 1982			25c. REGISTRAR'S SIGNATURE <i>None</i>							

lebenszeit

Lebenszeit zwischen Blüte und Tod eines einzelnen
Pflanzenteils als jene Lebensdauer

Se

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 3 5 6			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
32 M 35 34 20 1 29			Harriette Rayley			April 4, 1982							
1. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH 5 DAY 5 YEAR 40			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS: 41 YRS. IF UNDER 24 HRS MONTHS: DAYS HOURS MIN.				
7a. BIRTHPLACE MD			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.				
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher's Aide			12b. KIND OF BUSINESS OR INDUSTRY Education				
13a. STATE MD			13b. COUNTY A.A.			13c. CITY OR TOWN Riva			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 2778 Hamilton Estates 21140	
14. FATHER'S NAME John			15. MOTHER'S MAIDEN NAME Harriette L. Daniels			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 220-36-3851			17. INFORMANT Roger C. Bayly	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1830 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1830			19. DUE TO, OR AS A CONSEQUENCE OF (b) 19. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
20a. DATE OF OPERATION			20b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 10/12, 1981, to 4/4, 1982, that (I) (we) last saw the deceased alive on 1/15, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.													
22b. SIGNATURE R. J. Hochman, M.D.			22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 4/5/82				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) R. J. Hochman, M.D.			22f. ADDRESS 16 Murray Ave, Annapolis, Md										
23a. BURIAL, CREMATION, REMOVAL METHOD: Burial			23b. DATE April 6, 1982			23c. NAME OF CEMETERY OR CREMATORIAL Lakemont			23d. LOCATION CITY OR TOWN Davidsonville, Md				
24. FUNERAL DIRECTOR NAME John M. Taylor & Sons, Annapolis, Md			25a. DATE REC'D. BY REGISTRAR APR 7 1982			25b. REGISTRAR'S SIGNATURE Anne Jean Pace							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or either traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 0 8 3 5 7 EST							
1 - FOR REGISTRAR											REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR A							
HOWARD S. BEAGHAN, SR.						APRIL 21, 1982						10:00M							
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. UNDER 1 YEAR		8. UNDER 24 HRS							
Male			white	MON 9 3 17			64			YRS	MONTHS	DAYS	HOURS	MIN					
7e. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. NEVER MARRIED DIVORCED			10. BALTIMORE CITY OR COUNTY OF DEATH							
VA			USA			<input checked="" type="checkbox"/>			<input type="checkbox"/>			ANNE ARUNDEL COUNTY							
12. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12b. USUAL OCCUPATION (THEIR WORK FOR MOST OF WORKING LIFE)			12c. KIND OF BUSINESS OR INDUSTRY										
GLEN BURNIE			NORTH ARUNDEL HOSPITAL			foreman			allied Chemical										
13a. STATE Maryland												13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7551 B+A Blvd.	
14. FATHER'S NAME John Jacob												15. MOTHER'S MAIDEN NAME Willie Margaret Dorrrough							
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO UNKNOWN) YES			17. SOCIAL SECURITY NO. 127-10-300			17. INFORMANT Mabel Beaghan			18. ADDRESS 7551 B+A Blvd										
19. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1509												20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b)																			
DUE TO, OR AS A CONSEQUENCE OF (c)																			
DUE TO, OR AS A CONSEQUENCE OF (d)																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Buy manure metastasis																			
21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. AUTOPSY?			21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										
21e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTE MEDICAL EXAMINER)			21f. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21g. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21c OR PART II)													
21h. INJURY OCCURRED NOT WORK <input type="checkbox"/>			21i. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21j. LOCATION STREET			CITY OR TOWN										
21k. I certify that (i) this hospital attended the deceased from 4/21/82 19 10 4/21/82 19			and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) we (did) (did not) view the body after death.						COUNTY STATE										
22a. SIGNATURE Jorge B. Ramirez, M.D.			22b. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/21/82													
22d. PHYSICIAN'S NAME JORGE B. RAMIREZ, M.D.			22e. ADDRESS 7845 OAKWOOD ROAD GLEN BURNIE, MARYLAND 21061																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 4/22/82			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN										
24. FUNERAL DIRECTOR NAME Anatomy Board			25. DATE REC'D. BY REGISTRAR APR 27 1982			25e. REGISTRAR'S SIGNATURE James J. Blaustein													



1982 OKMOCG, INC.

1982 OKMOCG, INC. 1982 OKMOCG, INC.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8208358	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR	
JOSEPH Collison Beard						4 15 82						3:00 PM	
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male			White		Jan 28 14			68			MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. DATE OF BIRTH			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS		
Maryland			USA		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Anne Arundel MD.			MONTHS DAYS HOURS MIN.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Annapolis			PT. PRONOUNCED AT A.A.S.H.									12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
MD			AA		DAVIDSONVILLE			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			952 ST. GEORGE BARRETT		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
Martimer Burch Beard			Margaret										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMATION			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO			219-03-5577			Violet M. Beard						Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)													
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO, OR AS CONSEQUENCE OF METASTASIS TO THORACIC SPINE 6 (c) DUE TO, OR AS CONSEQUENCE OF CARCINOMA - LUNG.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.													
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from saw the deceased alive on above, (2) we (did / did not) view the body after death.			22b. DATE			22c. DEGREE			22d. DATE SIGNED				
George C. Somers			April 18 1982			ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			APR 21 1982			4/15/82	
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS										
George C. Somers			205 Ridgely Ave. Annapolis MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. STATE	
Burial			April 18 1982			Davidsonville MD			Davidsonville AA			MD	
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
John M. Taylor & Sons, Annapolis, MD						APR 21 1982			James J. O'Gorman				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8208359		
												REG. NO.	EST	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
LUCY CHRISTIN BELL						APRIL 21, 1982						7:25 P.M.		
1. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		Month Day Year December 13, 01			80			MONTHS DAYS		HOURS MIN.		
BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.				
St. Mary's County		USA					ANNE ARUNDEL COUNTY							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
GLEN BURNIE		NORTH ARUNDEL HOSPITAL					Clerical - Retired-May Company							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
MD		AA		Glen Burnie						620 Marlboro Road				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST				
		Sidney		Beavan				Lela		Jarboe				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS							
No		214-22-5176		Jane M. Robidoux, Same as 13										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cards you know Arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
5901 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Decompensated Congestive heart failure</i>														
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Acute Pericarditis with Sepsis</i>														
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).														
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE	
22a. I certify that (1) this hospital attended the deceased from 4-9, 1982, to 4-21, 1982, the (1) (we) last saw the deceased alive on 4-21, 1982, and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.												22c. DATE SIGNED 4-21-82		
22d. SIGNATURE <i>Edward Sherman</i>		22e. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		205 BALTIMORE-ANNAPOLIS BOULEVARD GLEN BURNIE, MARYLAND 21061										
EDWARD N. SHERMAN, M.D.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNTY			STATE	
Burial		24 April 82		Lorraine Park Cem.			Woodlawn			Baltimore			MD	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
James S. Kirkley, Glen Burnie, MD				APR 23 1982										

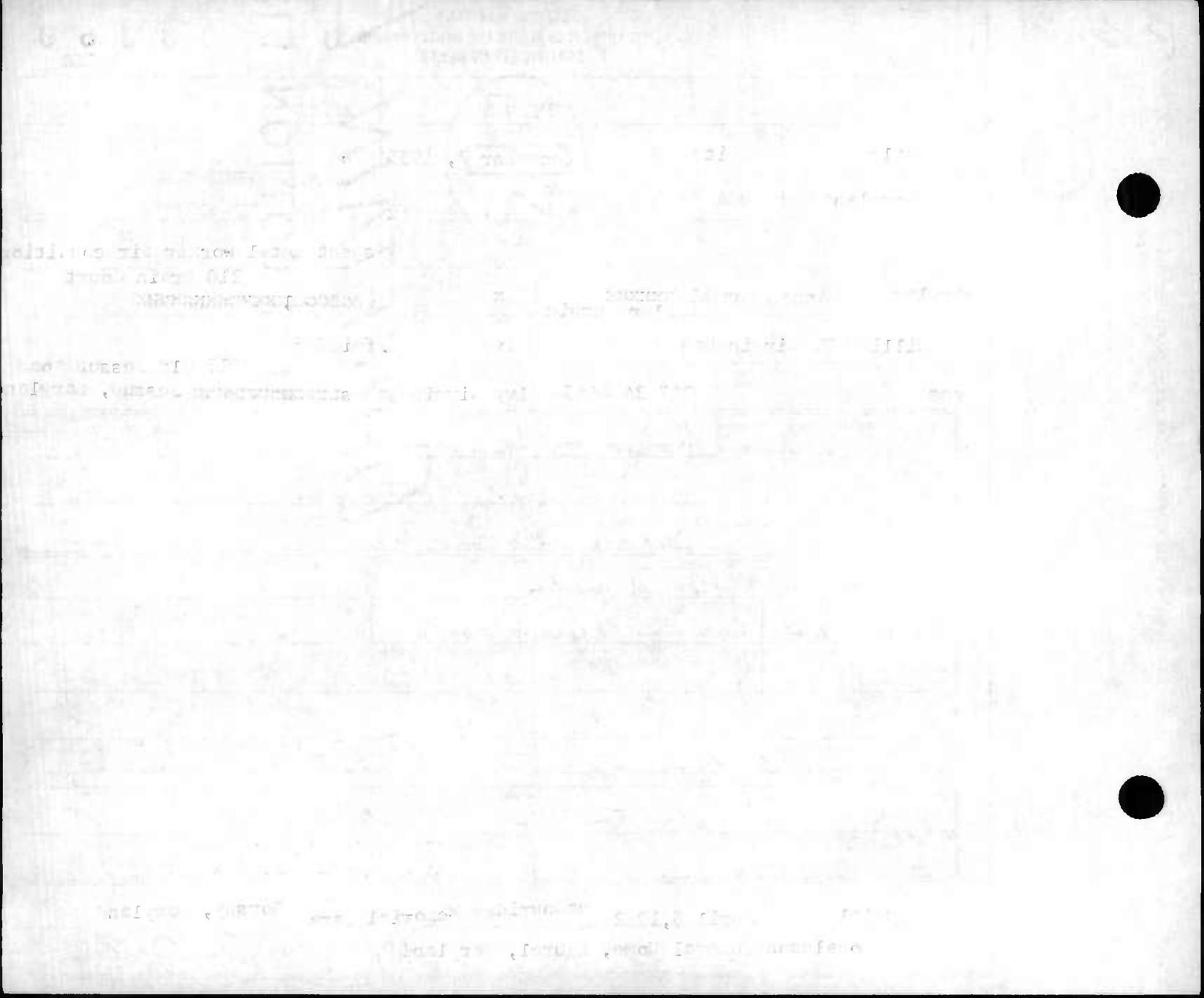
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 2 0 8 3 6 0 EST		
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR 7:15 P M		
			WILLIAM T. BIRMINGHAM						APRIL 5, 1982					
3 SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR December 7, 1935			6 AGE (IN YEARS LAST BIRTHDAY) 46 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10 CITY OR TOWN OF DEATH GLEN BURNIE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) sheet metal worker air conditioner			12b. KIND OF BUSINESS OR INDUSTRY 210 Crain Court					
13a. STATE Maryland			13c. COUNTY Anne Arundel			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 7917 Old Jessup Road					
14. FATHER'S NAME FIRST William T. MIDDLE Birmingham LAST			15. MOTHER'S MAIDEN NAME Ivy FIRST Pfeiffer MIDDLE			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. 217 34 4665			17. INFORMANT Ivy Birmingham 7917 Old Jessup Road Jessup, Maryland		
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 5710 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumothorax, spontaneous (c) Chronic pancreatitis 1 day 1 year														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b Carcinoma of floor of mouth														
19a. DATE OF OPERATION 29 MAR 82			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma, floor of mouth			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from February 19, 1982 to April 5, 1982, that (I) (we) last saw the deceased alive on May 8, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.														
22b. SIGNATURE James R. Appleton, M.D.			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED APR 16 1982					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES R. APPLETON, M.D.			22f. ADDRESS 310 Crain Highway, SW Glen Burnie, Maryland 21061											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE April 8, 1982			23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Memorial Park			23d. LOCATION CITY OR TOWN Dorsey, Maryland COUNTY STATE					
24. FUNERAL DIRECTOR NAME Donaldson Funeral Home, Laurel, Maryland						25a. DATE REC'D. BY REGISTRAR APR 16 1982			25b. REGISTRAR'S SIGNATURE James Jan North					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 0 8 3 6 1					
1. FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR									REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2b HOUR											
RICHARD L. BLACK						APR 24 1982			7:55P.M.								
1. SEX MALE			4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7b HOUR							
				A 18 21			60 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN							
7b BIRTHPLACE WASHINGTON, D.C.			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL								
10. CITY OR TOWN OF DEATH LAUREL, MD.			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CH. LOREN'S CENTER			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None			12b KIND OF BUSINESS OR INDUSTRY None								
13a STATE MD.			13b COUNTY Anne Arundel			13c CITY OR TOWN LAUREL			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS LAUREL, MD.					
14. FATHER'S NAME FIRST JOHN			MIDDLE C.	LAST BLACK	15. MOTHER'S MAIDEN NAME FIRST HELEN			LAST LATHROP			ADDRESS 4521 EAST WEST Hwy BETH.						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE			17. INFORMANT HELEN E. BLACK			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1739 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last BASAL CELL CARCINOMA			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 23 yrs					
19. MEDICAL CERTIFICATION			20. DATE OF OPERATION			21b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 4-24-82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE MARGARET W. MOLAND, MD			22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 4-24-82								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARGARET W. MOLAND, MD			22e. ADDRESS CH. LOREN'S CENTER LAUREL, MD			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation			23b. DATE APR/27/82			23c. NAME OF CEMETERY OR CREMATORIAL CEDAR HILL CREMATORIAL SURROUND P.G.CO., MARYLAND			23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME			ADDRESS 517 11TH ST. SE			25a. DATE REC'D. BY REGISTRAR APR 30 1982			25b. REGISTRAR'S SIGNATURE James Jean Nathan								

100 - 100

100 x 8

900 ft = 800 ft + 100 ft

900 ft = 800 ft + 100 ft

900 ft = 800 ft + 100 ft

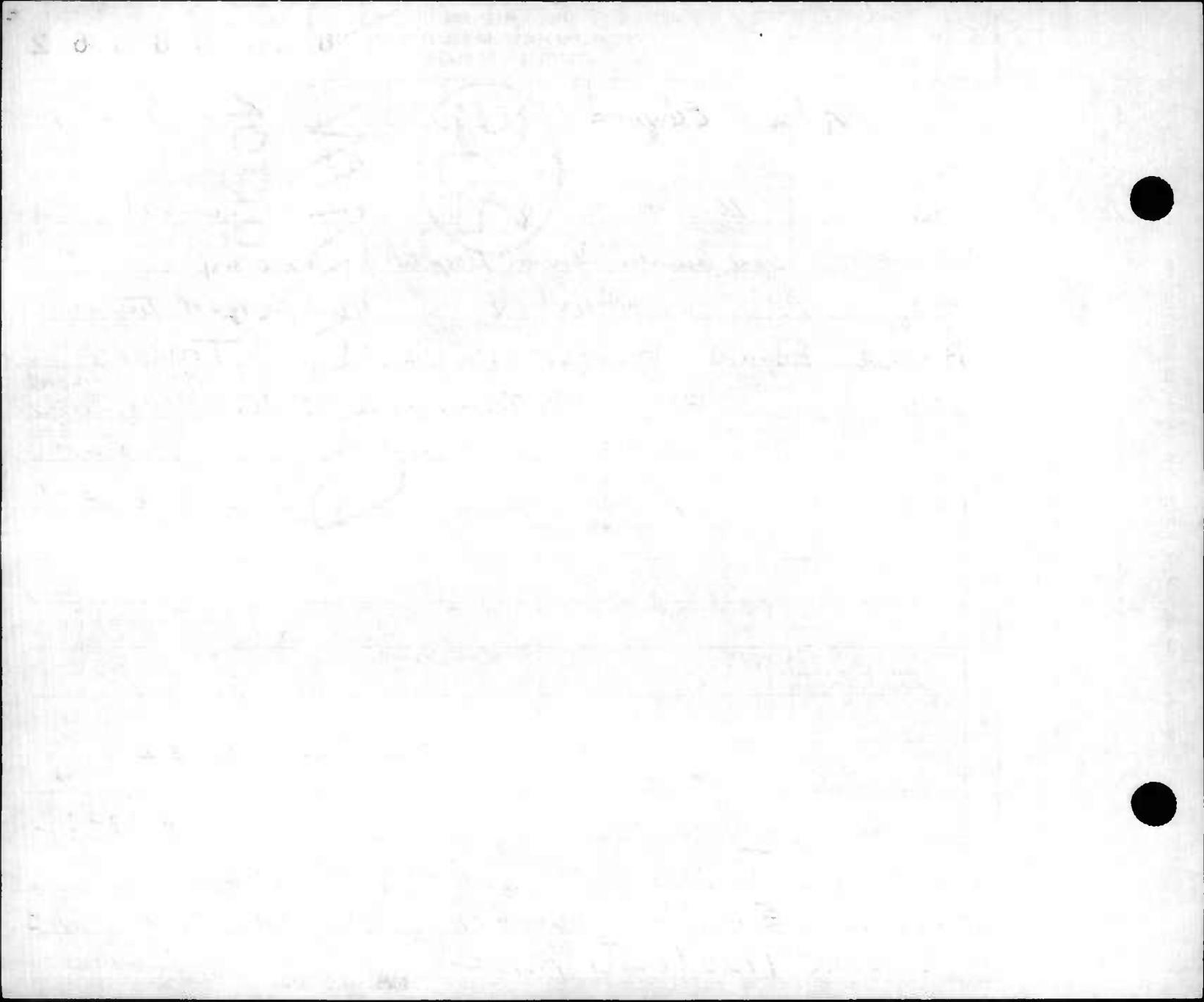
100 ft = 100 ft

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the funeral director's office with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at 301-767-2121.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8208362
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Archie Edward Blunt, Jr.						4-27-82			1245 PM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS			2b. HOUR IF UNDER 24 HRS HOURS MIN.		
Male		Black		3 - 1 - 24			58 YRS			1245 PM		
7a BIRTHPLACE COUNTRY		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
Md		U.S.A.					Anne Arundel					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION NOT IN SUCH A CITY, GIVE STREET ADDRESS Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cystic May			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MD		13b. COUNTY AA		13c. CITY OR TOWN ANNAPOLIS			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1162 Eastgate Terrace		
14. FATHER'S NAME Archie Edward Blunt		15. MOTHER'S MAIDEN NAME Eugia Toddles										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-16-4384		17. INFORMANT Ida Mae Blunt 713 E. Newton Drive			ADDRESS ANNAPOLIS, MD			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest												
7 4860 DUE TO, OR AS A CONSEQUENCE OF (b) pneumonia 6 weeks												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 3-19-82 to 4-27-82, that (I) (we) last saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.												
22b. SIGNATURE <i>John Testell</i>		22c. DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 4-28-82		
22e. ADDRESS Annapolis MD												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-1-1982		23c. NAME OF CEMETERY OR CREMATORIAL Churchton			23d. LOCATION CITY OR TOWN Churchton		COUNTY D.A.		STATE MD	
24. FUNERAL DIRECTOR NAME C. E. Hicks		ADDRESS 1922 Forest Drive		25a. DATE REC'D. BY REGISTRAR MAY 6 1982			25b. REGISTRAR'S SIGNATURE <i>John J. Hallinan</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	8208363							
1- STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
		<i>Eliza D. Hall Bowen</i>									<i>4-11-82</i>				<i>12:45 AM</i>			
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
Female		White			MONTH <i>3</i> DAY <i>23</i> YEAR <i>94</i>			88 YRS.			MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.				
MD		USA									Anne Arundel							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Annapolis		Anne Arundel General Hospital						Homemaker			Home							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS									
MD		A.A.		Annapolis		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2496 Riva Road			21401						
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																
Amos		L. Hall			Betty													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
No		—			Orville L. Bowen			2550 Riva Road										
Annapolis MD 21401																		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cerebrovascular accident</i>																		
4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Artherosclerosis</i> (c) <i>Hypertension</i>																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that () this hospital attended the deceased from saw the deceased alive on <i>4-9-82</i> , and that in () our opinion death occurred on the date and hour and from the causes stated above. () we (did) (did not) view the body after death.		22b. SIGNATURE <i>Dr. M. J. Hall MD</i>		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>4-12-82</i>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																
<i>G. Mitchell MD</i>		<i>205 Ridge Ave Annapolis</i>																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY			STATE					
Burial		April 14, 1982		Asbury Methodist			Barstow			Calvert			MD					
24. FUNERAL DIRECTOR NAME <i>John M. Taylor & Sons, Annapolis, MD</i>		ADDRESS			25a. DATE REC'D. BY REGISTRAR <i>APR 15 1982</i>			25b. REGISTRAR'S SIGNATURE <i>None</i>										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 0 8 3 6 4					
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Florence m.					Bradley	4			5	82	115A						
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.					
Female			White		MONTH	DAY	YEAR	86			YEARS	MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH							
Litchfield Pa.			U.S.		1 8 1896					Anne Arundel Co. MD.							
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)														
Crownsville			Fairfield Arundel Nursing Center Homemaker														
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE SKY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS							
MD			A.A		Annapolis		X			103 Greenberry Point Road 21402							
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (TYPE OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Ernest					Munn	Jennie			No		183-01-3342D		Lois J. Plizga		Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
2639 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)												2 months					
DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Chronic organic brain syndrome																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
N/A			N/A			<input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE						
22a. I certify that (I) (the hospital) attended the deceased from Aug 31, 1979, to April 15, 1982, that (I) (we) lost saw the deceased alive on March 31, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED					
22b. SIGNATURE Charles W. Kinzer												ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						April 15, 1982								
CHARLES W. KINZER, MD ANNAPOLIS, MARYLAND																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			24. FUNERAL DIRECTOR NAME					
Burial			April 1, 1982			Ulster			Ulster Bradford PA			John M. Taylor & Sons - Annapolis, MD					
												APR 7 1982					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8208365				
												REG. NO.				
1 - STATE REGISTRAR			FIRST			LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			Gertrude W.			Brizee			04 13 82			425pm				
3. SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
Female			white			MONTH DAY YEAR			80			YRS				
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9 BALTIMORE CITY OR COUNTY OF DEATH							
New York			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Anne Arundel Co			MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Annapolis			Anne Arundel General Hosp			Bookkeeper			Accounting							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Maryland			A.A.			Crofton			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1625 Eton Way				
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			Frances			Draft				
William			P. DeYoung													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
no			554-56-5999			Clarence Brizee, 1625 Eton Way, Md.			Crofton							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) respiratory arrest												Since 72 hours				
4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) stroke																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
None						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) this hospital attended the deceased from 4-10 1982, to 4-13 1982, that (I) (we) last saw the deceased alive on 4-13 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.																
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
Peter Schilder MD												4.13.82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS													
Peter Schilder MD			25 Shaw St Annapolis MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN							
Burial			4/20/82			Greenlawn Memo. Pk			Colma, California			COUNTY				
24. FUNERAL DIRECTOR			Beall Funeral Home			ADDRESS			25. DATE REC'D. BY REGISTRAR			UNREGISTERED SIGNATURE				
									APR 19 1982							
16000 Annapolis Rd., Bowie, Maryland																

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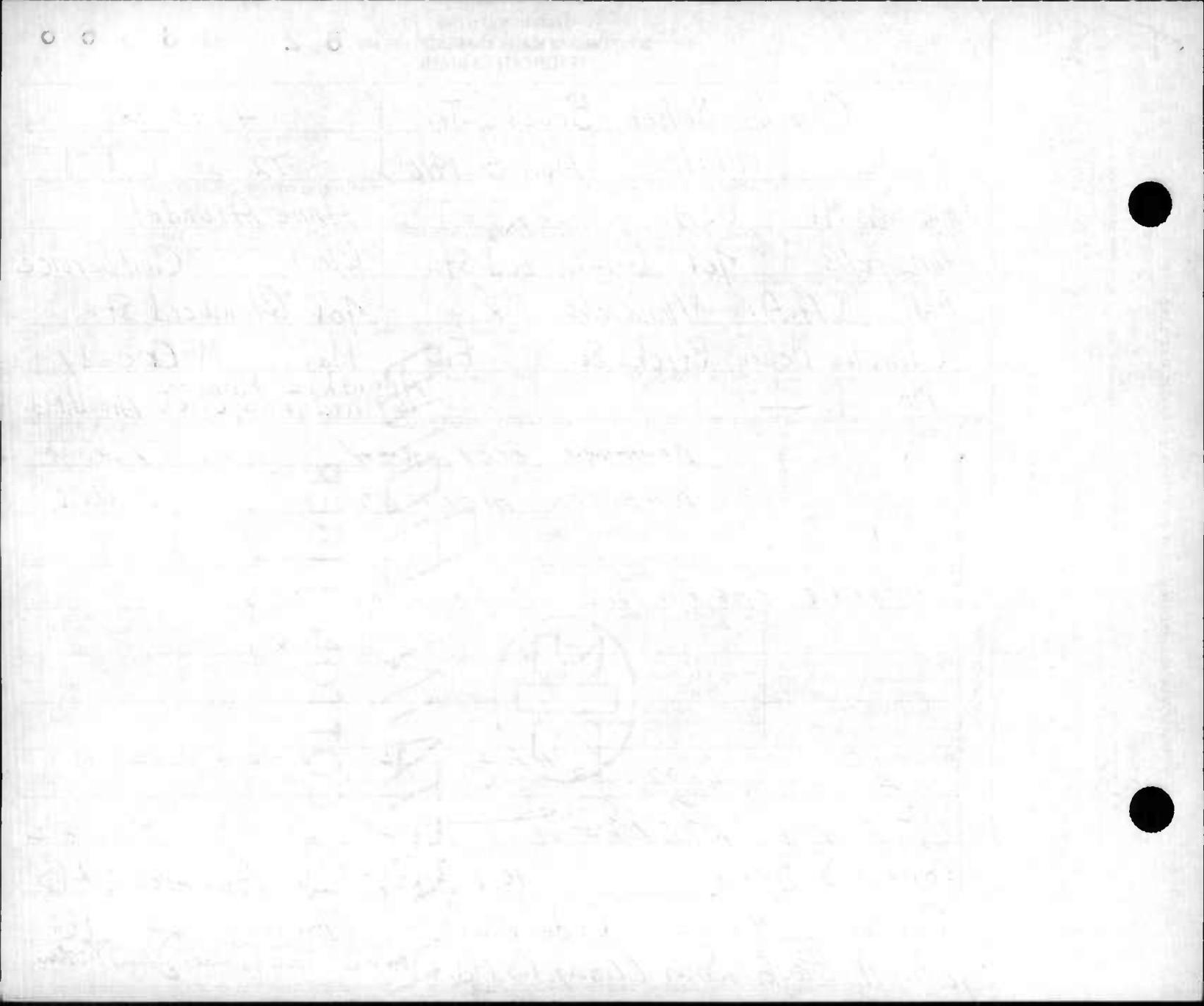
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign and file.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it may be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8208366	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Charles Nelson Brooks, Jr.						4			13	82			
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male			White	Month Day Year			72 YRS.			MONTHS	DAYS	HOURS	MIN.
7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Annapolis, Md.			USA						Anne Arundel MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A HOSPITAL, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Annapolis			701 Glenwood St.			Clerk			Civil Service				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS	
Md.			A.A.			Annapolis						701 Glenwood St.	
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
Charles Nelson Brooks, Sr.						Eva May McEready							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No			—			Arentha Monroe			1 hour				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			DUE TO, OR AS A CONSEQUENCE OF (b) DIABETES MELLITUS						10 yrs.				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSI			DUE TO, OR AS A CONSEQUENCE OF (c)										
2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
CHRONIC OBSTRUCTIVE PULMONARY DIS													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 11-2, 1972, to 1-28, 1982, that (we) lost saw the deceased alive on 1-28, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.													
22b. SIGNATURE			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED				
EDWARD S. BECK									4/15/82				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION CITY OR TOWN				
Burial			4-17-82			Cedar Bluff			Annapolis AA, Md.				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE OF REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
John M. Taylor & Sons			Annapolis, Md.			APR 21 1982			Frances Jean Hartman				

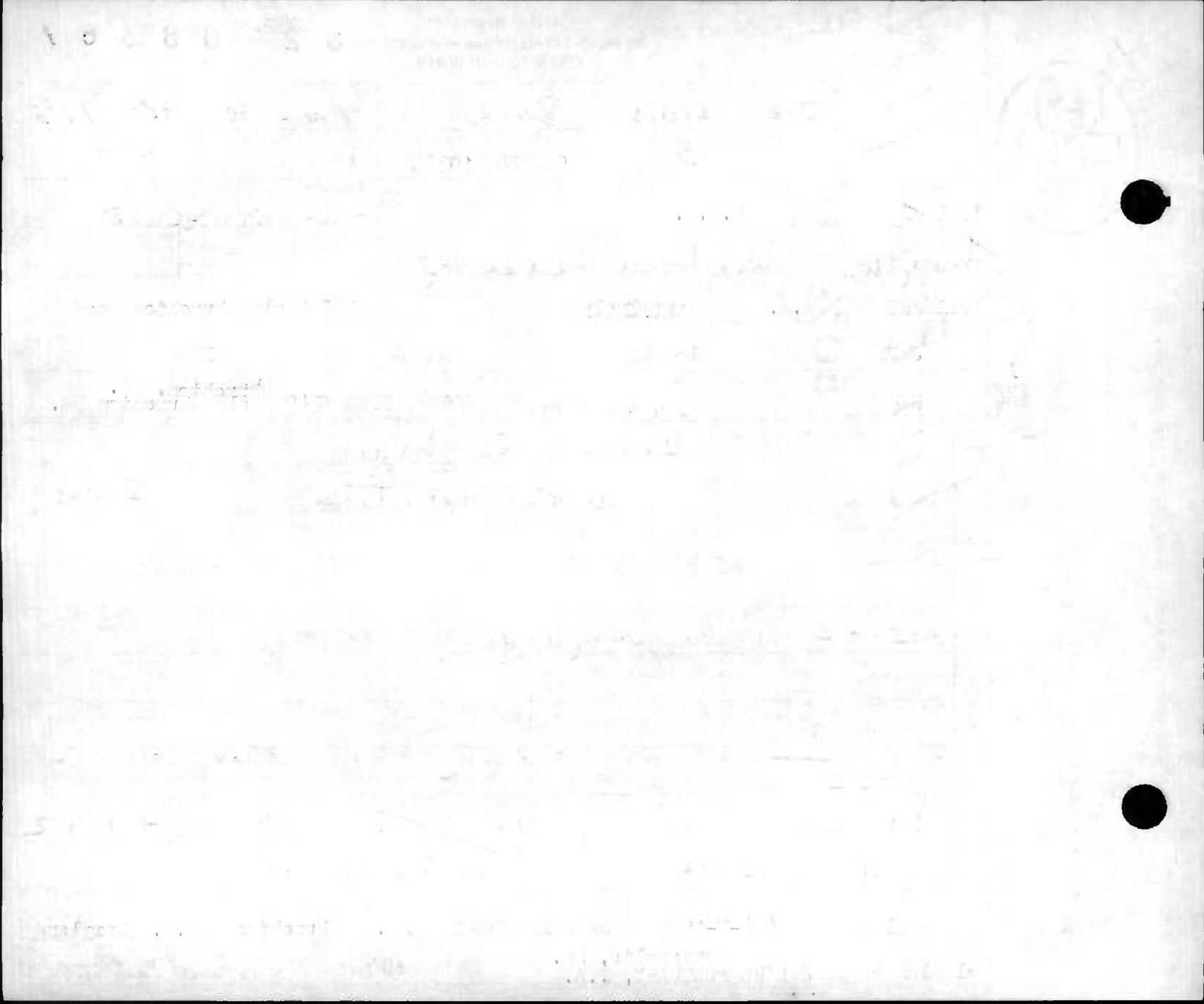


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8208367	
										REG. NO.	
1 - STATE REGISTRAR		FIRST MIDDLE LAST			2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR	
I. DECEASED NAME (TYPE OR PRINT)		Joe Louis Brooks			MARCH 30 1982					1102 PM	
3. SEX M		4 RACE B		5. DATE OF BIRTH MONTH 9 DAY 24 YEAR 1934		6 AGE (IN YEARS LAST BIRTHDAY) 47		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0 YRS		IF UNDER 24 HRS	
7a. BIRTHPLACE COUNTRY MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL CO MD.					
10 CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY					
13a STATE MARYLAND		13b COUNTY A.A.		13c CITY OR TOWN CHURCHTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 5349 Deale Churchton Road			
14 FATHER'S NAME FIRST JOHN		MIDDLE BROOKS		15 MOTHER'S MAIDEN NAME GAZELL		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		17. INFORMANT ADDRESS GERALDINE OFFER 5349 Deale Churchton Rd.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 1509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) _____ WITH metastases 2 mos	
										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION 3-2-82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca esophagus		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (the hospital) attended the deceased from saw the deceased alive on 19 above, (I) (we) (did not) view the body after death.		3-2 1982		19 82		to 3-30 1982			22c. DATE SIGNED 4-1-82		
22b. SIGNATURE K. Holstein		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HOLSTEIN		22e. ADDRESS 104 Forbes St									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4-4-1982		23c. NAME OF CEMETERY OR CREMATORIAL FRANKLIN CHURCH CEME.		23d. LOCATION CITY OR TOWN Churchton		COUNTY	STATE		
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.		25a. DATE REC'D. BY REGISTRAR APR 6 1982		25b. REGISTRAR'S SIGNATURE James J. Martin							

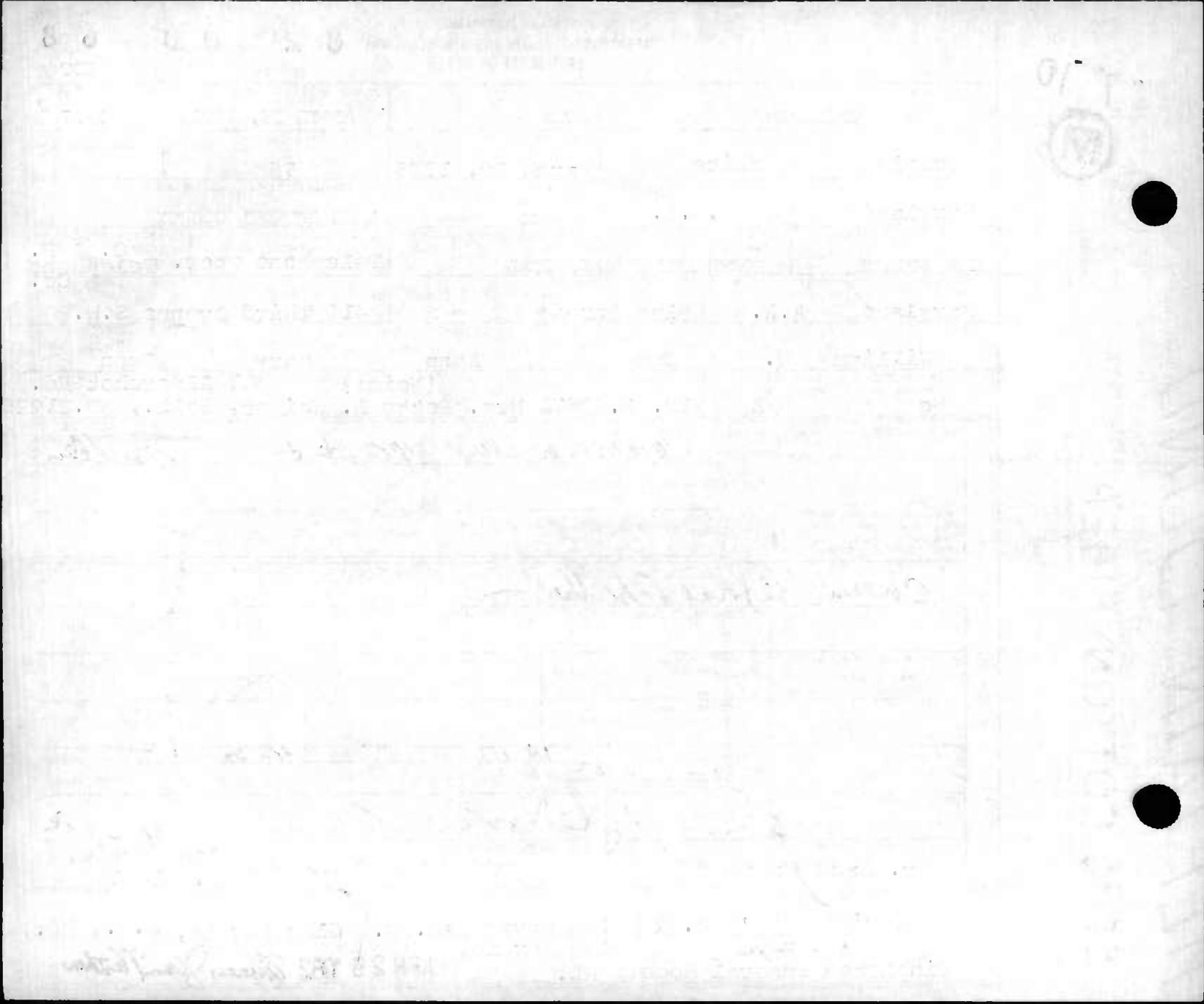


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at this office.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 1 0 8 3 6 8	EDT		
1 - STATE REGISTRAR									REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
CATHERINE Mary BROWN						APRIL 26, 1982						P 3:37 M			
3. SEX			4. RACE		5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)				
Female			White		March 30, 1906						76 yrs.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 1 YEAR MONTHS DAYS				
Maryland			U.S.A.					ANNE ARUNDEL COUNTY			IF UNDER 24 HRS HOURS MIN.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
GLEN BURNIE			NORTH ARUNDEL HOSPITAL			Telephone Oper.			C & P						
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Maryland			A.A.		Glen Burnie						419 Third Avenue S.W.				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST				
William W. Cox						Anna Mary Bunn									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No			N/A 212.03.6367A			(Neice) Mrs. Betty L. Weimer, Balt., MD. 21229			617 Aldershot Rd.			sudden			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i>												
4360			DUE TO, OR AS A CONSEQUENCE OF (b) _____												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			Chronic atrial fibrillation -												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1977</u> , 19_____, to <u>4-26-1982</u> , that (I) (we) last saw the deceased alive on <u>4-26-1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			Glen Burnie, 300 Hospital Drive, MD. 21061			4-22-82			
Dr. Jack Stern, MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN						
Burial			30 Apr. 82			Glen Haven Mem. Pk.			Glen Burnie, A.A., MD.						
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Singleton Funeral Home			MD.			APR 29 1982			James Jan Kester						

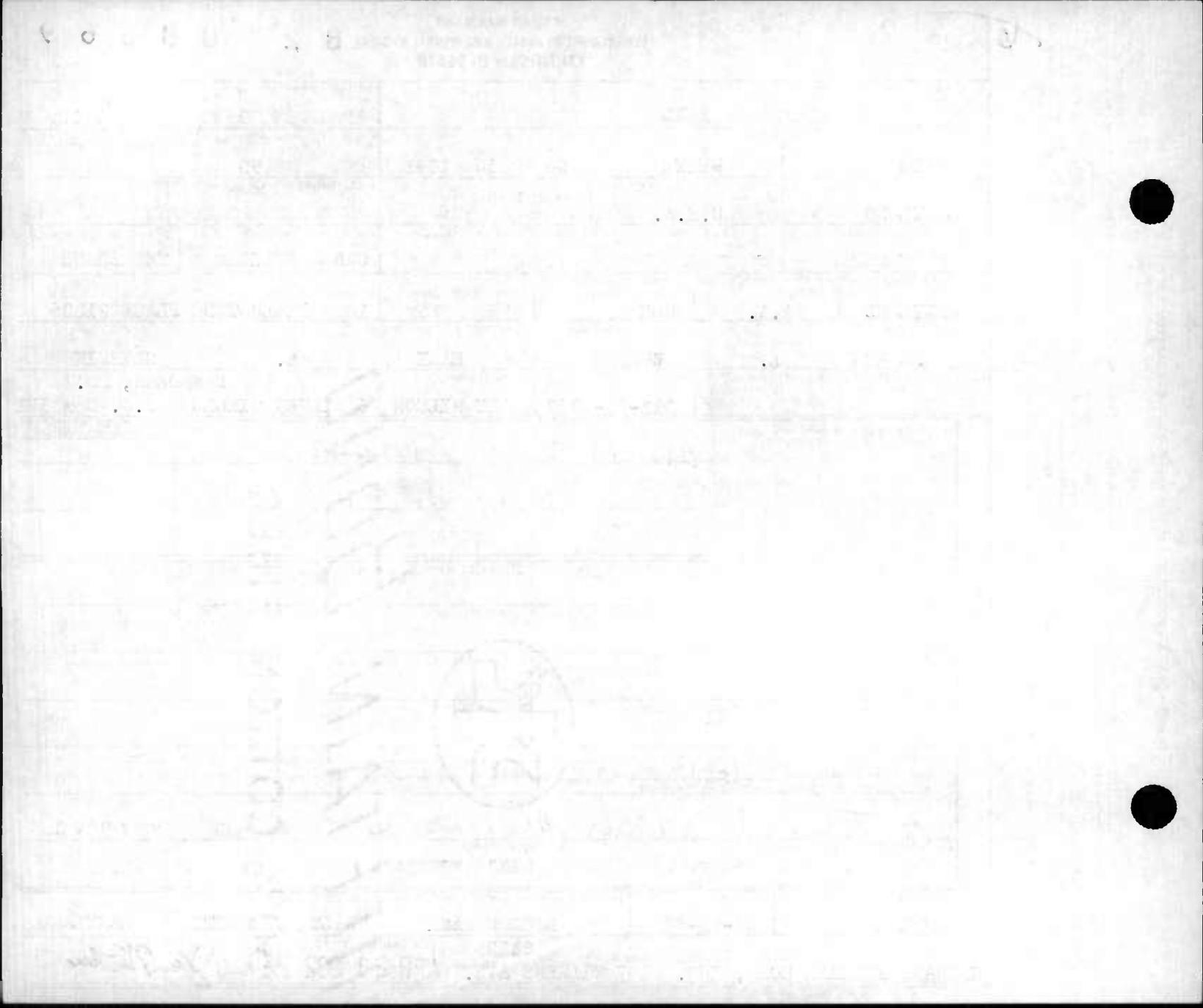


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 0 8 3 6 9				
												REG. NO.				
1 - STATE REGISTRAR												EST				
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
		CLARENCE		EARL		BURMAN			APRIL 18, 1982					7:30 P M		
3. SEX		4 RACE		5. DATE OF BIRTH			MONTH		DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		WHITE		MARCH 08 14 1891			MONTH		14	1891	90 yrs		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED		<input checked="" type="checkbox"/>	NEVER MARRIED	<input type="checkbox"/>	WIDOWED	<input type="checkbox"/>	DIVORCED	<input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND		U.S.A.											ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY			
GLEN BURNIE		NORTH ARUNDEL HOSPITAL						CABLE SPlicer					TELEPHONE			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
MARYLAND		A.A.		ORCHARD BEACH			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1004 FIELDSTONE PLACE 21226							
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST		
		GEORGE		L.		BURMAN		MARY		E.		GRiffin				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADULT RESP. DISTRESS.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO		212-05-0762			MARY WILSON		PASADENA, MD.									
1629		DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA OF THE LUNG.</u>			DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>4/18</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					19 82 , to 4 18 19 82											
22b. SIGNATURE <u>H-Towidian, M.D.</u>		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4/19/82											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAMID A. TOWIDIAN, M.D.		22e. ADDRESS 2334 MOUNTAIN RD. PASADENA, MD. 21122														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 04-23-82		23c. NAME OF CEMETERY OR CREMATORIAL LOUDON PARK			23d. LOCATION CITY OR TOWN BALTIMORE CITY		COUNTY		STATE MARYLAND					
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.		ADDRESS 4107 WILKENS AVE.			25a. DATE REC'D. BY REGISTRAR APR 21 1982		25b. REGISTRAR'S SIGNATURE <u>Frances Jean Hartman</u>									
BP _____																
DHMH-16 50M 1/81 (VRA 15, 4)																



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 7 days of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8208370 EST								
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST BENJAMIN			MIDDLE FRANKLIN			LAST CALVERT			2a DATE OF DEATH APRIL 3, 1982	MONTH	DAY	YEAR	2b HOUR 9:40P M	
3 SEX Male			4 RACE White			5. DATE OF BIRTH May 1 1909			6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.			IF UNDER 1 YEAR MONTHS			IF UNDER 24 HRS DAYS HOURS MIN					
7a BIRTHPLACE COUNTRY Md.			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY											
10 CITY OR TOWN OF DEATH GLEN BURNIE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter			12b. KIND OF BUSINESS OR INDUSTRY Bd. of Ed.											
13a. STATE Md.			13b. COUNTY A.A.			13c. CITY OR TOWN Pasadena			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 8419 Garland Rd. 21122								
14 FATHER'S NAME William Walter Henry Calvert						15. MOTHER'S MAIDEN NAME Victoria Irene Lopez														
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO. 217-07-3554			17. INFORMANT Mary C. Calvert (same as 13e)			ADDRESS											
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4960			Chronic Obstructive Lung Disease												APPROXIMATE INTERVAL BETWEEN UNDERLYING AND DEATH Year					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)																	
			DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a DATE OF OPERATION 9/9			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 4-3-19			21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 4-3-19 above, (I) (we) did not view the body after death.															and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE J. Stern						DEGREE A.B.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED Apr 5 1982								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JACK I. STERN, M.D.			22e. ADDRESS 300 HOSPITAL DR. GLEN BURNIE, MD. 21061																	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE ADDRESS			23c. NAME OF CEMETERY OR CREMATORIAL Westview Memorial			23d. LOCATION CITY OR TOWN COUNTY STATE			Baltimore, Md.								
24 FUNERAL DIRECTOR NAME George J. Gonc F.H. 4001 Ritchie Hwy.			25a. DATE REC'D. BY REGISTRAR NAME George J. Gonc F.H. 4001 Ritchie Hwy.			25b. REGISTRAR'S SIGNATURE APR 5 1982														

Laboratory

1000' above sea level

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 0 8 3 7 1	EST		
1. FOR STATE REGISTRAR									REG. NO.						
2. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
HELEN SINCLAIR CAMPBELL						APRIL 7, 1982						8:40AM			
SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female			White	Month Day Year Apr. 8, 1897			84			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Scotland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY			MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Own Home						
13a. STATE Michigan			13c. COUNTY Wayne			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 4947 Lannoo						
14. FATHER'S NAME FIRST Francis			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Mary			MIDDLE	LAST Sinclair						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A			17. INFORMANT (Neice) ADDRESS Mrs. Margaret M. Sheppard 21061			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF HAS CVD Urinary edema Due to, or as a consequence of renal insufficiency (c) Type II, diabetes mellitus, including hypertension			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF HAS CVD Urinary edema Due to, or as a consequence of renal insufficiency (c) Type II, diabetes mellitus, including hypertension			19. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Cerebral infarction with left hemiplegia, old			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. DATE OF OPERATION N/A			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) N/A			21d. LOCATION STREET CITY OR TOWN COUNTY STATE						
21a. DATE OF OPERATION N/A			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) N/A			21d. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) N/A			21d. LOCATION STREET CITY OR TOWN COUNTY STATE						
22b. I certify that (I) (this hospital) attended the deceased from March 30, 1982, to April 7, 1982, that (I) (we) last saw the deceased alive on April 7, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated below. The deceased died on April 7, 1982, and did not view the body after death.			22c. DATE SIGNED April 7, 1982			22d. DEGREE ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS 325 HOSPITAL DR., GLEN BURNIE, MARYLAND 21061						
22b. I certify that (I) (this hospital) attended the deceased from March 30, 1982, to April 7, 1982, that (I) (we) last saw the deceased alive on April 7, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated below. The deceased died on April 7, 1982, and did not view the body after death.			22c. DATE SIGNED April 7, 1982			22d. DEGREE ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS 325 HOSPITAL DR., GLEN BURNIE, MARYLAND 21061						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Apr. 8, 82			23c. NAME OF CEMETERY OR CREMATORIAL Security Proc. Inc. Catchsville, Balt., MD.			23d. LOCATION TOWNSHIP COUNTY STATE						
24. FUNERAL DIRECTOR NAME J. Easter Singleton Funeral Home			ADDRESS Glen Burnie, MD.			25a. DATE REC'D. BY REGISTRAR APR 12 1982			25b. REGISTRAR'S SIGNATURE Chances Jan Martin						

W. E. L. S. 1

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3 RETAIN PAGE 3 WITH FORM PM-3 FOR BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 08372					
1- STATE REGISTRAR																	
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. MONTH DAY YEAR		
WILLIAM MICHAEL CARRAWAY												<input checked="" type="checkbox"/> 4 27 1982					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD			2d. MONTH DAY YEAR		
Male		White		10 23 1963		18						<input checked="" type="checkbox"/> 4 27 1982			1:45 a.m.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Md.			USA									Anne Arundel County					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis			Anne Arundel General Hospital									Boat			Transport		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			14. FATHER'S NAME		
MD			AA			Sherwood Forest						535 Little John Hill			William B. Carraway		
15. MOTHER'S MAIDEN NAME															Julia		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			Rhody			Same as #13		
No			—									William B. Carraway					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cranio-cerebral trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?					
												<input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
			1+ 8:xx 4-27-1982			Driver in auto/fixed object impact.						Thomas Pt. Rd. near Arundel Rd., A.A.			Md.		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															DATE SIGNED 4-27-82		
ACTUAL SIGNATURE			M.D. Assistant MEDICAL EXAMINER														
EXAMINER'S NAME (TYPE OR PRINT)			111 Penn St., Balto., Md. 21201														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			25a. REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Cremation			April 28, 1982			Ft. Lincoln			Brentwood			P.G. MD					
24. FUNERAL DIRECTOR NAME			ADDRESS														
John M. Taylor & Sons, Annapolis, MD																	

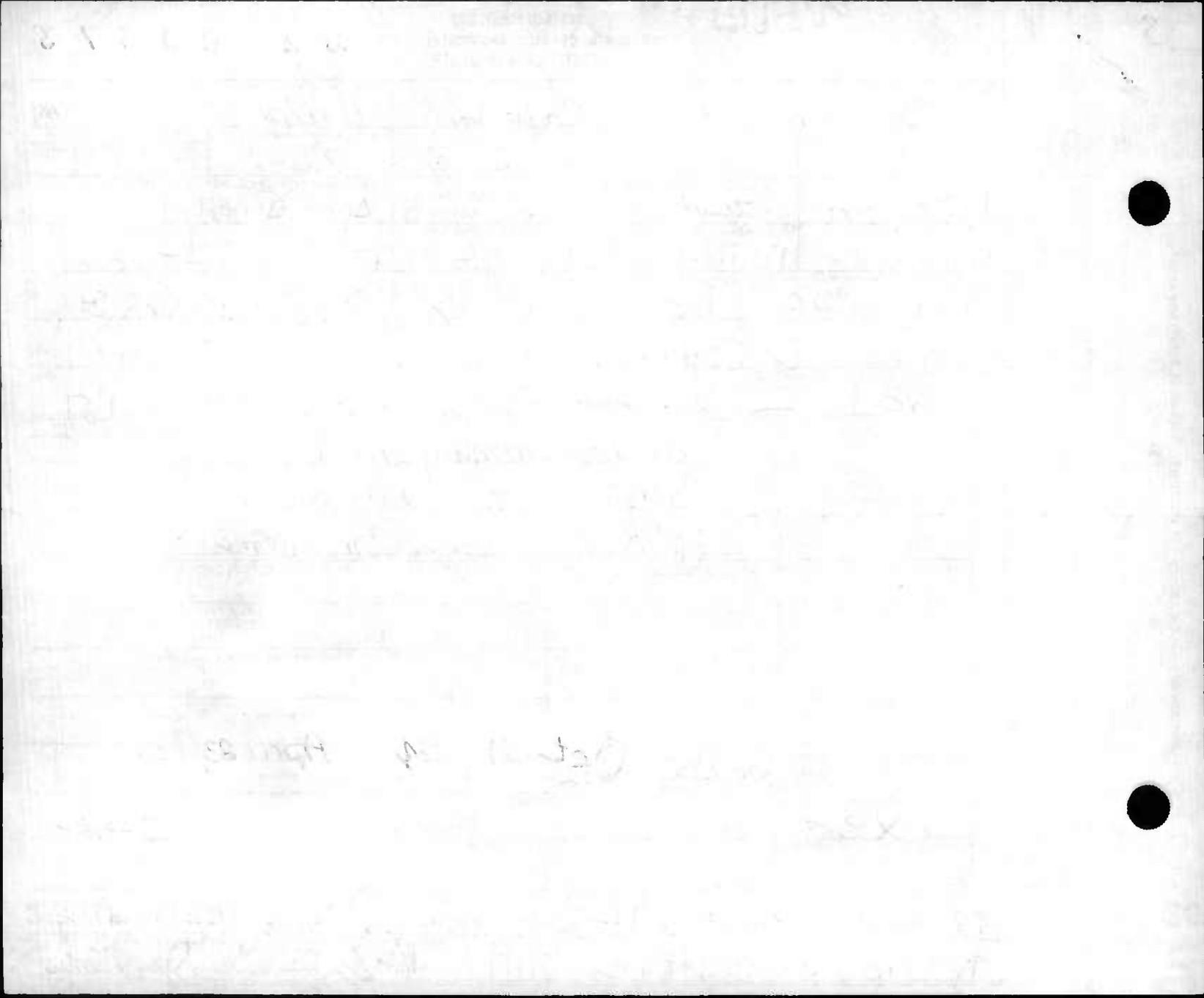
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8208373									
					REG. NO.									
1. FOR STATE REGISTRAR	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR						
1 DECEASED NAME (TYPE OR PRINT)	Crampton	V	Catterton	4/21/82				9 50AM						
3 SEX	M	RACE	w	S. DATE OF BIRTH	MONTH	DAY	YEAR							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	35 Maryland	7b. CITIZEN OF WHAT COUNTRY?	USA	MARRIED	<input type="checkbox"/>	NEVER MARRIED	<input type="checkbox"/>	WIDOWED	<input type="checkbox"/>	DIVORCED	<input type="checkbox"/>			
10 CITY OR TOWN OF DEATH	30 Millerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Millerstown Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Farmer			12b. KIND OF BUSINESS OR INDUSTRY	Tobacco					
13. STATE	35 Md	13a. COUNTY	PG	13d. INSIDE CITY LIMITS?	YES	<input type="checkbox"/>	NO	13e. STREET ADDRESS	9115 Luckerman St					
14. FATHER'S NAME	Jones	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	Mallie									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	NO	16b. SOCIAL SECURITY NO	219-54-4403	17. INFORMANT	Ella Griffith			ADDRESS	Bothum Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
IMMEDIATE CAUSE (a) 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					DUE TO, OR AS A CONSEQUENCE OF (b) atherosclerotic cardiovascular									
DUE TO, OR AS A CONSEQUENCE OF (c) peripheral vascular disease emphysema														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE									
22a. I certify that <input type="checkbox"/> (I) (this hospital) attended the deceased from saw the deceased alive on <u>April 5</u> 19 <u>82</u> and that in (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.	22b. SIGNATURE <u>De Kohler</u>	DEGREE	ATTENDING PHYSICIAN	<input checked="" type="checkbox"/> DIRECTOR	<input type="checkbox"/> STAFF	PHYSICIAN	22c. DATE SIGNED 4/23/82							
22e. ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE 4-23-82	23c. NAME OF CEMETERY OR CREMATORIAL M+ Zion Cemetery	23d. LOCATION CITY OR TOWN Bothum	23e. COUNTY	STATE									
24. FUNERAL DIRECTOR NAME	ADDRESS	Owings	25a. DATE REC'D. BY REGISTRAR MAY 7 1982	25b. REGISTRAR'S SIGNATURE James Jan Kather										
DPH	0000	DHMH-16 25M (VRA 15, 4) 1/79												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
<i>Robert P. Chambers</i>						<i>April 8 82</i>			<i>APRIL</i>	<i>8</i>	<i>82</i>	<i>0334</i>		
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS		
<i>M</i>		<i>Caucasian</i>	<i>JULY 11 DAY 1905</i>			<i>76</i>			<i>MONTHS</i>	<i>DAYS</i>	<i>HOURS</i>	<i>MIN.</i>		
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY					
<i>BALTIMORE MD</i>		<i>USA</i>												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a. USUAL OCCUPATION RETIRED			12b. KIND OF BUSINESS OR INDUSTRY STOCK BROKER			MD.			
<i>FORT MEADE MD</i>		<i>KIMBROUGH ARMY COMM HOSPITAL</i>												
14. FATHER'S NAME		FIRST	MIDDLE	LAST	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <i>314 TERNWING DRIVE</i>						
<i>MARION</i>		<i>HARRISON</i>		<i>CHAMBERS</i>				<i>LAURA</i>			<i>PURSLEY</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS						
<i>YES</i>		<i>RET-1AUG65</i>			<i>215-05-2820</i>			<i>HELEN CHAMBERS 314 TERNWING DR ARNOLD MD</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>80 min</i>														
4254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF both (b) <i>Cardiomyopathy</i> years DUE TO, OR AS A CONSEQUENCE OF and (c) <i>Chronic Obstructive Lung Disease</i> years														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <i>2 APRIL 1982</i> , 19 <i>82</i> , to <i>8 APRIL</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>19</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated														
22b. SIGNATURE <i>James D. Fitz</i>		22c. DEGREE <i>Major</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>8 APRIL 1982</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS												
<i>JAMES D. FITZ, MAJOR, MEDICAL CORPS KIMBROUGH ARMY COMM HOSP FORT MEADE MD</i>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE							
<i>BURIAL</i>		<i>APRIL 10, 1982</i>		<i>DRUID RIDGE CEMETERY PIKEVILLE</i>			<i>PIKEVILLE</i>		<i>BALTIMORE MD</i>					
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
<i>BARRANCO F.H.</i>		<i>SEPT. 13 1982</i>			<i>James Janice</i>									
DHMH - 16 50M 1/B1 (VRA 15, 4)														

35

APR 11 1967

CONFIDENTIAL

THE ARKANSAS COURT

OF APPEALS

OPINION OF THE COURT CONCERNING THE CONSTITUTIONALITY OF THE
STATE TAX ON INCOME RECEIVED BY THE STATE FROM THE

STATE FEDERAL DEBT

ARMED FORCES VOLUNTEER ACT

DISCUSSION

FACTS

CHARACTER

HABERSON

MURKIN

ATTACHMENT TO OPINION OF THE COURT CONCERNING THE CONSTITUTIONALITY OF THE STATE TAX ON INCOME RECEIVED BY THE STATE FROM THE

50

APRIL 8

S. WALTER LEE

S. WALTER LEE

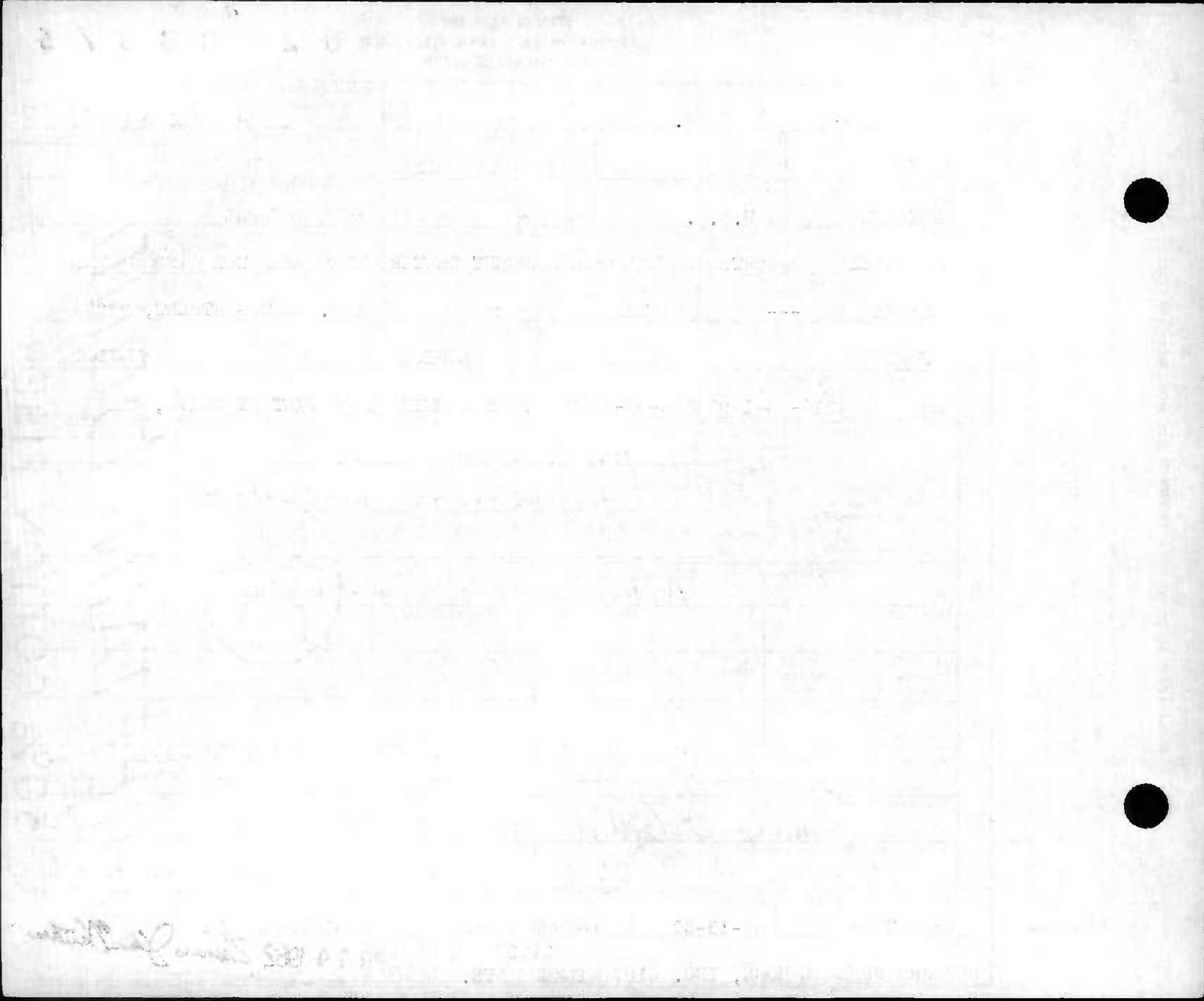
THOMAS D. GILL, ATTORNEY GENERAL, REX HARRISON, ATTORNEY FOR THE STATE, AND ROBERT L. COOPER, ATTORNEY FOR THE DEFENDANT.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked off Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 3 7 5						
										REG. NO.						
1. FOR STATE REGISTRAR			FIRST			MIDDLE			LAST			2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
1. DECEASED NAME (TYPE OR PRINT)			LOUISE			A.			CONRAD			4	12	82	93 A.M.	
2. SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE			WHITE			MONTH 09 DAY 12 YEAR 02			79 YRS			MONTHS	DAYS	HOURS	MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
MARYLAND			U.S.A.						ANNE ARUNDEL							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
GLEN BURNIE			NORTH ARUNDEL CONVALESCENT CENTER			OWNER OPERATOR			FOOD STALL							
13a. STATE MARYLAND			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1 N. HILTON STREET, 21229							
14. FATHER'S NAME FIRST JOHN			LAST SCHMID			15. MOTHER'S MAIDEN NAME LOUISE			LAST ALBICK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. NO 216-05-1492			17. INFORMANT JOHN SCHMID			ADDRESS 1908 VICTORY DRIVE, 21227							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Pyneumonia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease																
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis Generalized																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Arteriosclerosis Generalized																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from October 19, 1979, to April 12, 1982, that (I) (we) last saw the deceased alive on May 22, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 4/12/82						
22b. SIGNATURE Francis J. Gold			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANCIS J. GOLD			22e. ADDRESS PO Box 627 Sevenn Park Md 21146													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 04-13-82			23c. NAME OF CEMETERY OR CREMATORIAL LOUDON PARK			23d. LOCATION CITY OR TOWN BALTIMORE CITY			COUNTY	STATE MARYLAND			
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.			ADDRESS 21229			25a. DATE REC'D. BY REGISTRAR APR 14 1982 Charles J. [Signature]			25b. REGISTRAR'S SIGNATURE							
2006 BP																
DHMH-16 30M 2/80 (VRA 15, 4)																

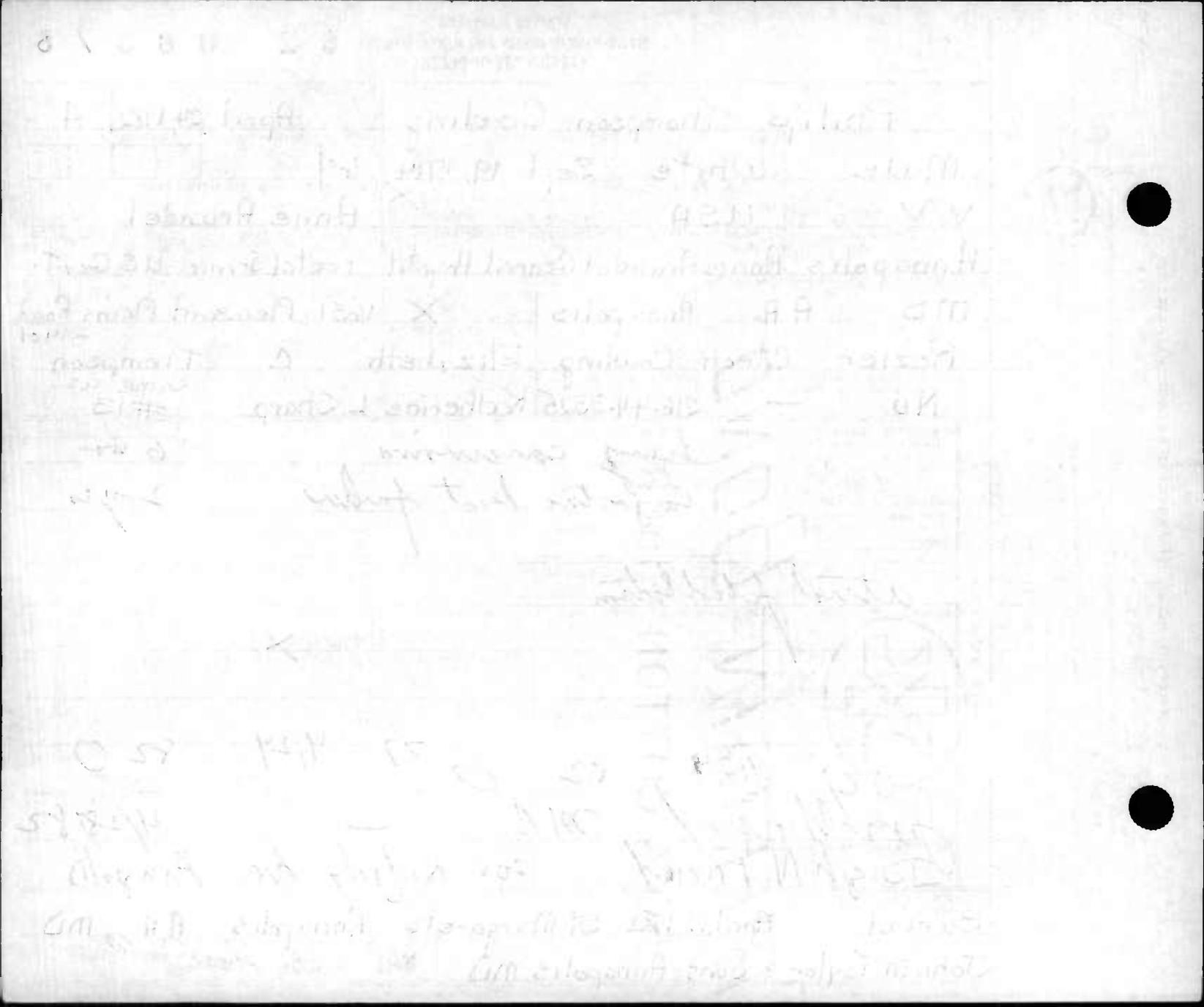


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified and requested

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 82 08376	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Philip Thompson Cowling						April 24, 1982						A M	
3. SEX			4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	IF UNDER 24 HRS			
Male			White	Sept. 19, 1914	MONTH DAY YEAR	61			MONTHS DAYS	HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
WV			USA						Anne Arundel			MD.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Annapolis			Anne Arundel General Hospital			Postal Service			U.S. Gov't.				
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			13e. STREET ADDRESS					
MD			A.A.	Annapolis				1651 Pleasant Plains Road			21401		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
Rozier Clean Cowling						Elizabeth			C.		Thompson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			— 216-443325			Katherine L. Sharp			Same as #13				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sinus carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>1629</u> (b) <u>Congenital heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>atm flutter</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>4/24/82</u> to <u>4/24/82</u> , that (I) (we) last saw the deceased alive on <u>4/24/82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <u>Joseph N. Finey</u>			22c. DEGREE <u>M.D.</u>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>4/28/82</u>				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joseph N. Finey</u>			22f. ADDRESS <u>205 Ridgely Ave. Annapolis</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <u>April 26, 1982</u>			23c. NAME OF CEMETERY OR CREMATORIUM <u>St. Margaret's</u>			23d. LOCATION CITY OR TOWN <u>Annapolis</u>			COUNTY <u>MD</u>	STATE
24 FUNERAL DIRECTOR NAME <u>John M. Taylor & Sons - Annapolis, MD</u>			ADDRESS			25a. DATE REC'D. BY REGISTRAR <u>MAY 4 1982</u>			25b. SIGNATURE <u>John M. Taylor</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #6 per phone call w/Fun. Home FOR 4/19/82 rc			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			8208377
						REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR
GAITHER, ROLAND CREEK			4 - 14 1982			2:45 PM
3. SEX			4. RACE			5. DATE OF BIRTH
Female			Black			Month Day Year Feb 2 1898
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			6. AGE (IN YEARS LAST BIRTHDAY)
Md			U.S.A.			74 84 YRS
7c. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			8. MARRIED WIDOWED NEVER MARRIED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
ANNAPOLIS			120 Southville Ave			Domestic
13a. STATE			13b. COUNTY			13c. CITY OR TOWN
Md			A.A.			ANNAPOLIS
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
William			Elizabeth			16b. SOCIAL SECURITY NO. AmKm
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			19. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			17. INFORMANT ADDRESS Mrs Cassie Fashkin 94 EAST ST
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DUE TO, OR AS A CONSEQUENCE OF (b) Cardiovascular Disease			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINS
DUE TO, OR AS A CONSEQUENCE OF (c)						YEARS
20a. DATE OF OPERATION			20b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 3-13 1982 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We did) (did not) view the body after death.			22b. SIGNATURE Ronald Pickett MD			22c. DATE SIGNED 4/15/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 111 CATHEDRAL ST ANNAPOLIS MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Apr 19-1982			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS ANNAPOLIS
Burial			23d. LOCATION CITY OR TOWN ANNAPOLIS A.A. md			23e. RESTRANCTION None
24. FUNERAL DIRECTOR NAME C.E. Hicks III			25a. DATE REC'D. BY REGISTRAR APR 19 1982			25b. REGISTRAR SIGNATURE None
15.4						

11-60-20 U.S. Geological Survey
Topographic Sheet

100' contour interval

1000' contour interval

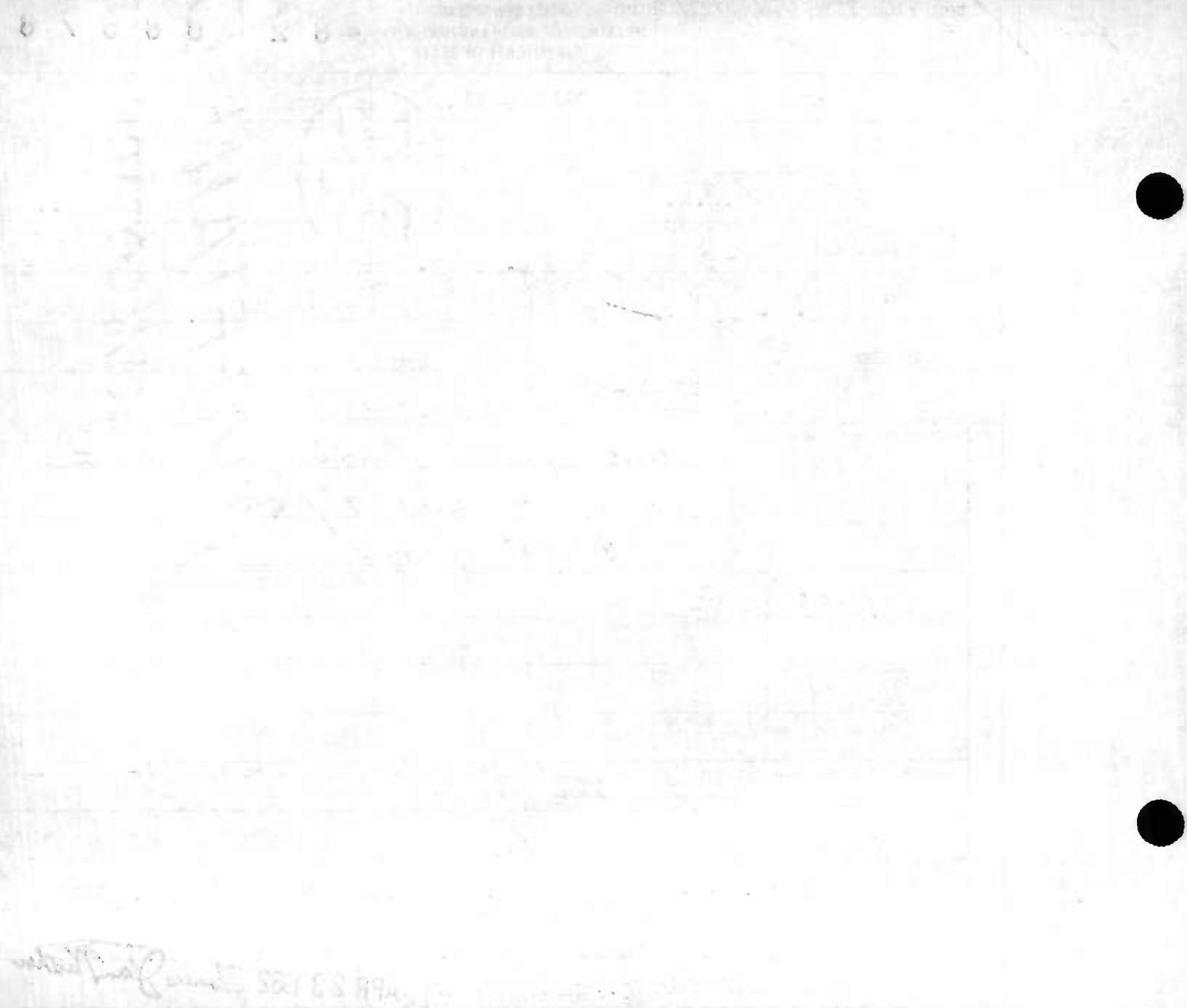
0.5 km. scale 1:250,000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #16b Film G566 4/27/82 rc				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 8 3 7 8
								REG. NO.
1. DECEASED NAME (TYPE OR PRINT)		FIRST GEORGE	MIDDLE WESLEY	LAST DAVIS, SR.		2a DATE OF DEATH MONTH DAY YEAR		2b. HOUR
3. SEX Male		4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 21, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co., MD.			
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Gen. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance Manager (Port Author		12b. KIND OF BUSINESS OR INDUSTRY city)
13a. STATE Md.		13b. COUNTY A. A.	13c. CITY OR TOWN Brooklyn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 5504 Moore St. (21225)	
14. FATHER'S NAME FIRST Jesse		MIDDLE M.	LAST Davis		15. MOTHER'S MAIDEN NAME Estella		Parsons	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. W.W.II		16c. INFORMANT 232-16-0185 232-15-0185		ADDRESS Helen M. Davis (same as 13e)		
<p>18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <i>Acute Myocardial infarction</i></p> <p><i>4100</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary artery disease with previous</i></p> <p>{ DUE TO, OR AS A CONSEQUENCE OF (c) <i>Myocardial infarction</i></p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immediately</i></p>								
<p>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)</p> <p><i>Diabetes mellitus</i></p>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
<p>22a. I certify that (I) (We) attended the deceased from <u>1/11/67</u> to <u>4/18/82</u>, 19 <u>82</u>, that (I) (We) last saw the deceased alive on <u>3/22/82</u>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.</p>								
22b. SIGNATURE <i>Morton Krieger</i>		22c. DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 4/19/82		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Morton Krieger, M.D.		22e. ADDRESS 606 Hammonds Lane, Brooklyn, Md. 21225						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/21/82	23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN Glen Burnie, A.		23e. COUNTY Anne Arundel	
24 FUNERAL DIRECTOR George J. Goncze, 4001 Ritchie Hg., Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR APR 22 1982 25b. REGISTRATION NUMBER Chances						

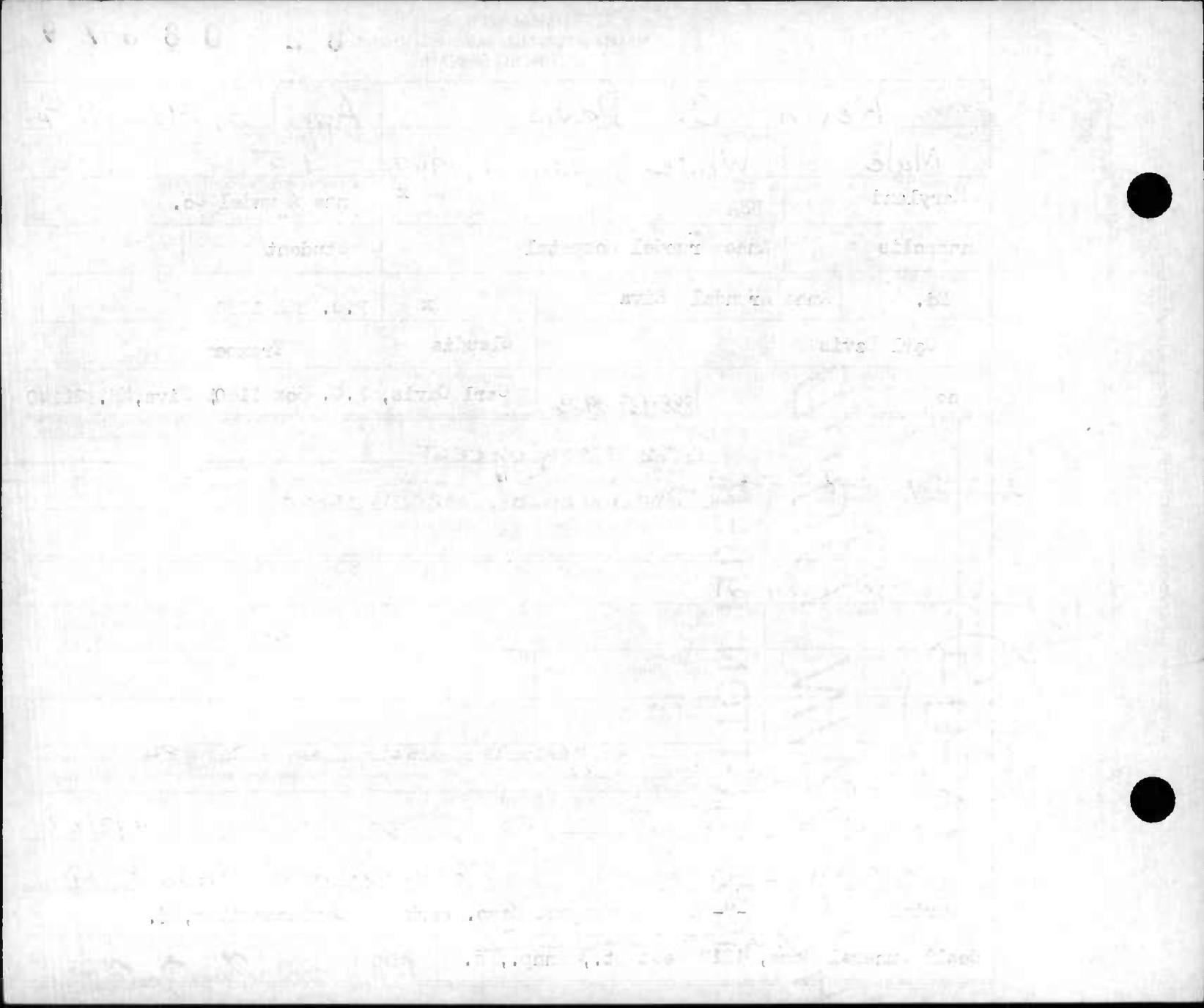


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8208379			
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Kevin C. Davis												April 3, 1982		11 ¹⁰ PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
Male		White		Jan. 1, 1967			15								
7. BIRTHPLACE STATE OR FOREIGN		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co.								
Maryland		USA													
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Anne Arundel Hospital										12a. USUAL OCCUPATION (TYPE OR PRINT) Student		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Riva			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS P.O. BOX 1180					
14. FATHER'S NAME Carl Davis		MIDDLE			LAST			15. MOTHER'S MAIDEN NAME Claudia			16. ADDRESS Carl Davis, P.O. Box 1180, Riva, Md. 21140				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		(IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO. 888-15-3926			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART 1. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <i>Respiratory arrest</i></p> <p>4830</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.</p> <p>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia, mycoplasma</i></p> <p>{ DUE TO, OR AS A CONSEQUENCE OF (c)</p>															
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.</p> <p><i>Tetralogy of Fallot</i></p>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
<p>22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 30, 1982</u>, to <u>April 3, 1982</u>, that (I) (we) last saw the deceased alive on <u>April 3, 1982</u>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.</p>															
22b. SIGNATURE <i>Donald R. Schneider</i>		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4/3/82							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Donald R. SCHNEIDER, MD		22f. ADDRESS 2538 Davidsonville Rd. Gambrills, MD													
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 4-7-82			23c. NAME OF CEMETERY OR CREMATORIAL Lakemont Memo. Park			23d. LOCATION Davidsonville, Md.							
24. FUNERAL DIRECTOR Beall Funeral Home, 1212 West St., Annapolis, Md.								25a. DATE REC'D. BY REGISTRAR APR 6 1982		25b. REGISTRAR'S SIGNATURE <i>James J. Smith</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death be retained by the hospital or attending physician.

certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 8 3 8 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
<i>Henry Irvin Dear</i>						4	27	82	5 P.M.				
3. SEX			RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male			Cauc.	MONTH	DAY	YEAR	76						
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Maryland			U.S.A.						A.A.C.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Millersville, MD			Knollwood manor			military status			Coast Guard				
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			14. STREET ADDRESS			15. MOTHER'S MAIDEN NAME		
Maryland			Anne Arund.	Glen Burnie				7869 Creiley Rd. Apt. 426			First	Middle	Last
Charles			Dear	Rose	Walker								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			18. APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH				
no			218051307			Bertha Harper 833 Clifton Ave. Arnold, Md. 21012 (daughter)							
18. CAUSE OF DEATH (Enter only one cause per line for item 1b, and item 1c) PART 1: DEATH WAS CAUSED BY			IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b) <i>Respiratory distress</i> <i>aspiration pneumonia</i>							
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.													
19. PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b.													
20a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
					YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHITE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 16</i> , 19 <i>81</i> , to <i>April 27</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>4/25</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>M. Kaplan</i>						DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>4/27/82</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>M. Kaplan M.D.</i>						22e. ADDRESS <i>7845 Oakwood Rd. Glen Burnie</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>04/30/82</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Loudon Park</i>			23d. LOCATION CITY OR TOWN <i>Baltimore, Maryland</i>		23e. COUNTY STATE				
24. FUNERAL DIRECTOR <i>Daniel A. Naylor</i>		25a. DATE REC'D. BY REGISTRAR <i>APR 30 1982</i>		25b. REGISTRAR'S SIGNATURE <i>James Jan Wester</i>									
BP _____													
DHMH - 16 50M 1/81 (VRA 15, 4)													

200 ft. in thickness. It is brownish with brownish streaks.

yellow brown yellow brown yellow

grey brown grey brown grey brown
grey brown grey brown grey brown

200 ft.
brown
brown

-200 ft. 100 ft. 100 ft. 100 ft.

200 ft.

200 ft. 100 ft. 100 ft. 100 ft.

brownish grey brownish grey brownish grey brownish grey

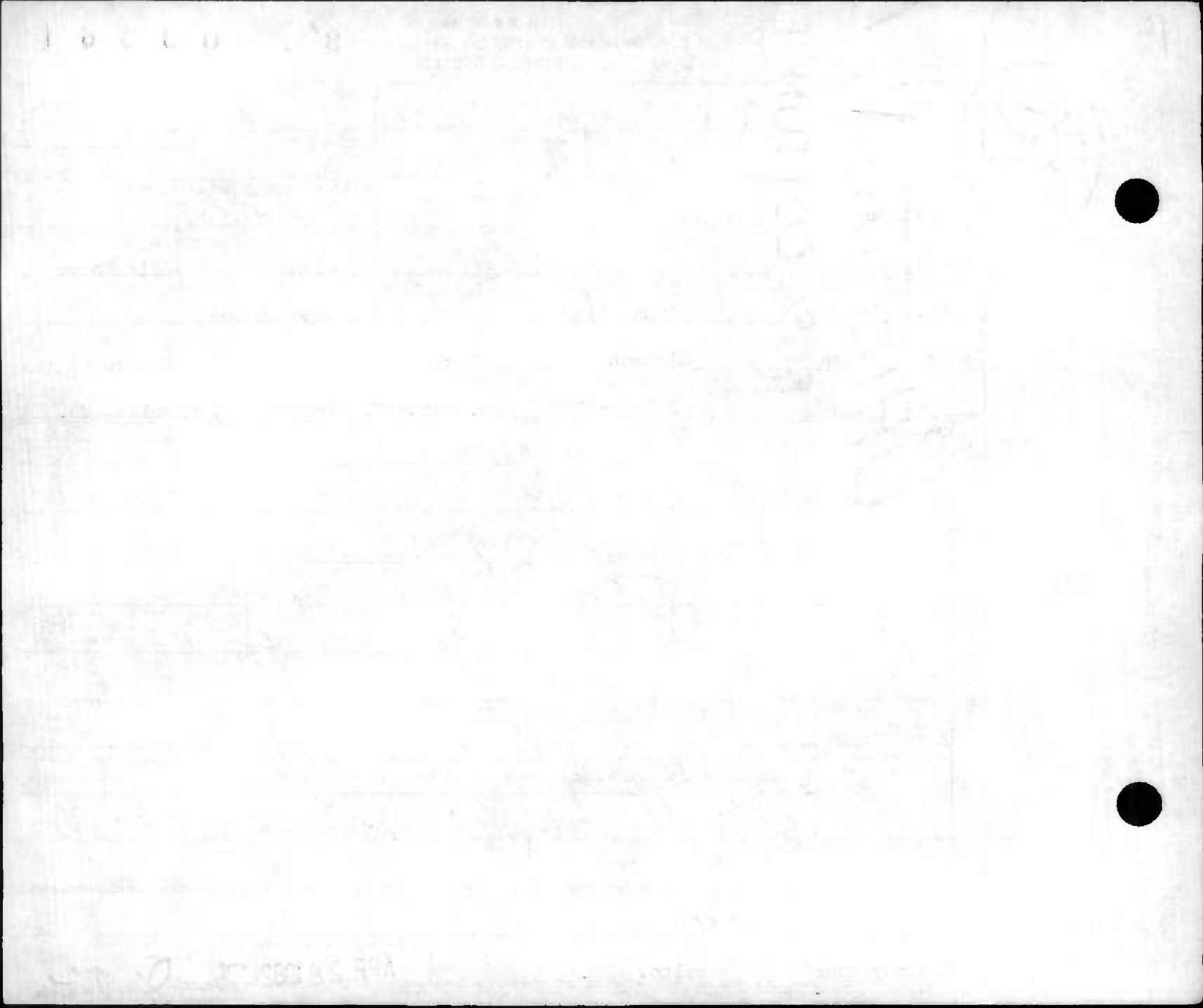
grey brown grey brown grey brown grey brown

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 0 8 3 8 1	
												REG. NO.	
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OF)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR	
			<i>John Rigid Van Dickson</i>						<i>Apr 23 1982</i>			<i>5 19 PM</i>	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
<i>M</i>			<i>W</i>			<i>Jan 7 1912</i>			<i>70</i>			MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS	
<i>Arizona</i>			<i>U.S.A.</i>						<i>A.A.C.O.</i>			HOURS MIN.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			<i>AAGH</i>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
<i>Annapolis</i>									<i>Colonel</i>			<i>Air Force</i>	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												MD.	
13a STATE			13b COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS	
<i>Md.</i>						<i>Annapolis</i>						<i>1 Gladden Road</i>	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
<i>James Van Dickson</i>			<i>Pearl</i>										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
<i>Yes</i>			<i>215-38-9722</i>			<i>Mrs. Betty V. Dickson</i>			<i>Annapolis, Md.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<i>Cardiac Arrest</i>												<i>immediate</i>	
4240 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) <i>Congestive heart failure</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Mitral regurgitation</i>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic obstructive pulmonary disease</i>													
19a. DATE OF OPERATION <i>12/3/81</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Lumbar laminectomy</i>			19c. AUTOPSY? <input type="checkbox"/> 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>An</i>			21f. LOCATION STREET <i>1021</i>			21g. CITY OR TOWN <i>Baltimore</i>	21h. COUNTY <i>Maryland</i>	21i. STATE <i>MD</i>		
22a. I certify that (s) this hospital attended the deceased from <i>Jan 82</i> to <i>Apr 1 1982</i> , to <i>1982</i> , that (s) (we) last saw the deceased alive on <i>1982</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (if well I did) did not see the body after death.													
22b. SIGNATURE <i>H. May</i>			22c. DEGREE <i>Medical Director</i>			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>4/23/82</i>				
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>H. May</i>			22g. ADDRESS <i>1021</i>										
23e. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>			23f. DATE <i>4/24/82</i>			23g. NAME OF CEMETERY OR CREMATORIUM <i>Balto., Md.</i>			23h. LOCATION CITY OR TOWN <i>Baltimore</i>				
24. FUNERAL DIRECTOR NAME <i>Anatomy Board</i>			25a. ADDRESS <i>Balto., Md.</i>			25b. DATE REC'D. BY REGISTRAR <i>APR 28 1982</i>			25c. REGISTRAR'S SIGNATURE <i>James J. Kehoe</i>				

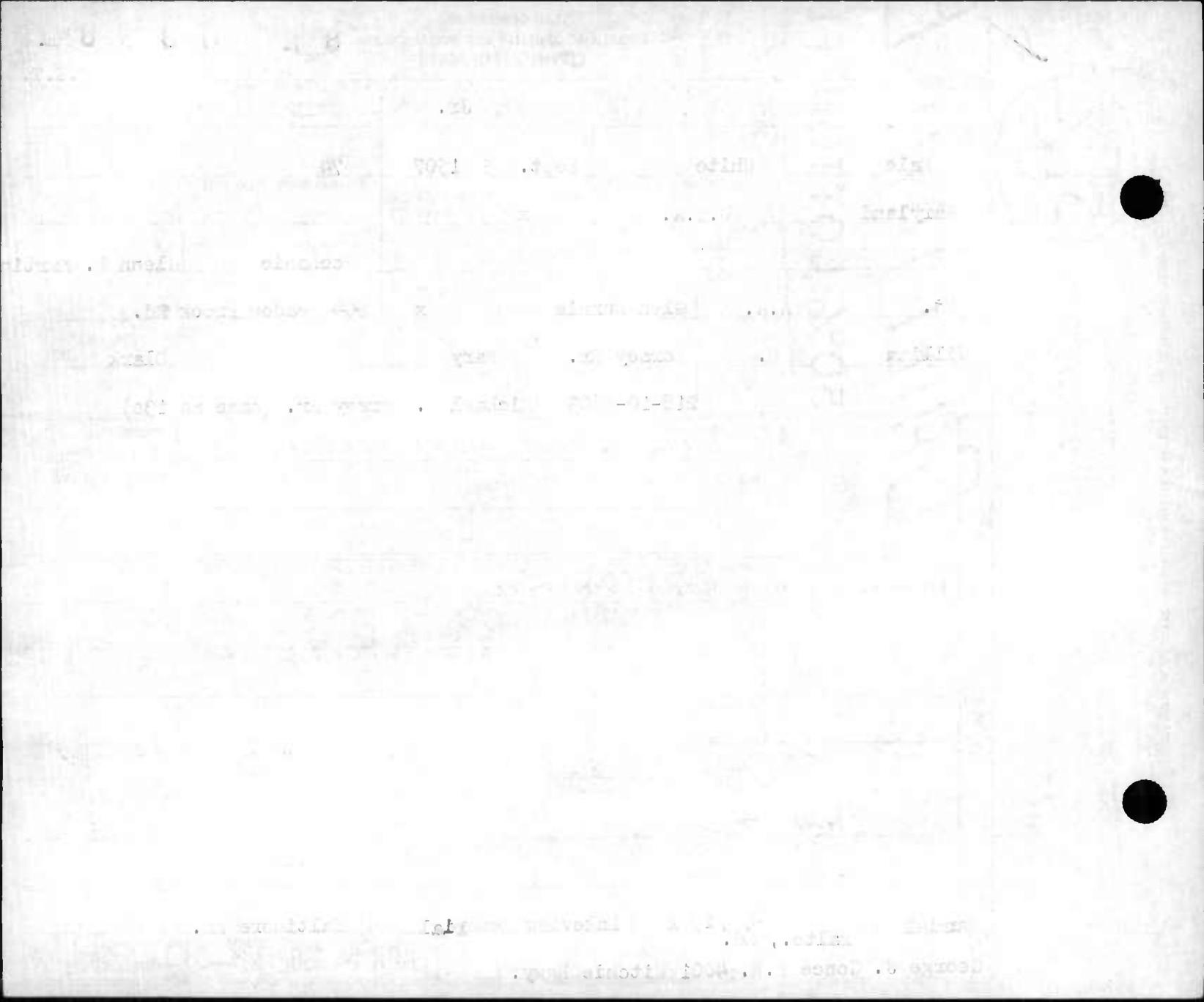


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use on the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 3 8 2	E.S.T.	
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
WILLIAM H. DORSEY Jr.						APRIL 2, 1982						4:25P M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Male		White		Sept. 5 1907			74 YRS.			IF UNDER 24 HRS		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS DAYS HOURS MIN.		
Maryland		U.S.A.					ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
GLEN BURNIE		NORTH ARUNDEL HOSPITAL								Mechanic		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
Md.		A.A.		Glen Burnie						904 Meadow Brook Rd.		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
William		H.	Dorsey Sr.		Mary					Clark		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS
(If Yes, give war or dates)				218-10-5603				Michael W. Dorsey Sr. (same as 13e)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH less than half hour.												
4275 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <u>PROFOUND ORGANIC BRAIN SYNDROME,</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE
22a. I certify that (I) (this hospital) attended the deceased from 3/22, 1982, to 4/2, 1982, that (I) (we) did not view the body after death. saw the deceased alive on 4/2, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>S. P. Mundra, M.D.</u>		22c. DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>4/3/82</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S. P. MUNDRA, M.D.</u>					22e. ADDRESS <u>203 E. PATAPSCO AVENUE BALTIMORE, MARYLAND 21225</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY			STATE
Burial		4/6/1982		Lakeview Memorial			Baltimore Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. GJSTRAR'S SIGNATURE				
Balto., Md.					APR 5 1982			<u>George J. Gonce F.H.</u>				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 08383		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED				MONTH	DAY	YEAR	2b. HOUR	
Calvin Wilson Durner						4	18	1982	A	M				
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD				MONTH	DAY	YEAR	2d. HOUR	
Male	white	Nov. 28, 1915	66 yrs.			4	18	1982	A	M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				Anne Arundel				
Maryland	U.S.A.									MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY				
Annapolis	Anne Arundel General					Signal Dept.				B & O R.R.				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS				11 Coaling Road			
Maryland	Anne Arundel	Harmans												
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST				MIDDLE	LAST	Marie Sappington					
Elza		Durner	Ethel						ADDRESS 919 Bargagni					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No	N/A	(Son) Mr. William C. Durner, Rd. 21032												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN	COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <u>E. L. Haag</u>			TITLE (SPECIFY) M.D. <u>Dept 49</u>				MEDICAL EXAMINER				DATE SIGNED <u>4/15/82</u>			
EXAMINER'S NAME (TYPE OR PRINT) <u>E. L. Haag</u>			ADDRESS <u>Annapolis, MD</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/21/82				23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Mem. Pk.				23d. LOCATION CITY OR TOWN Glen Burnie, A.A., MD.			
24. FUNERAL DIRECTOR NAME <u>D. Hall</u>			ADDRESS Singleton Funeral Home				25a. DATE REC'D. BY REGISTRAR APR 20 1982				25b. REGISTRAR'S SIGNATURE <u>James J. Hall</u>			

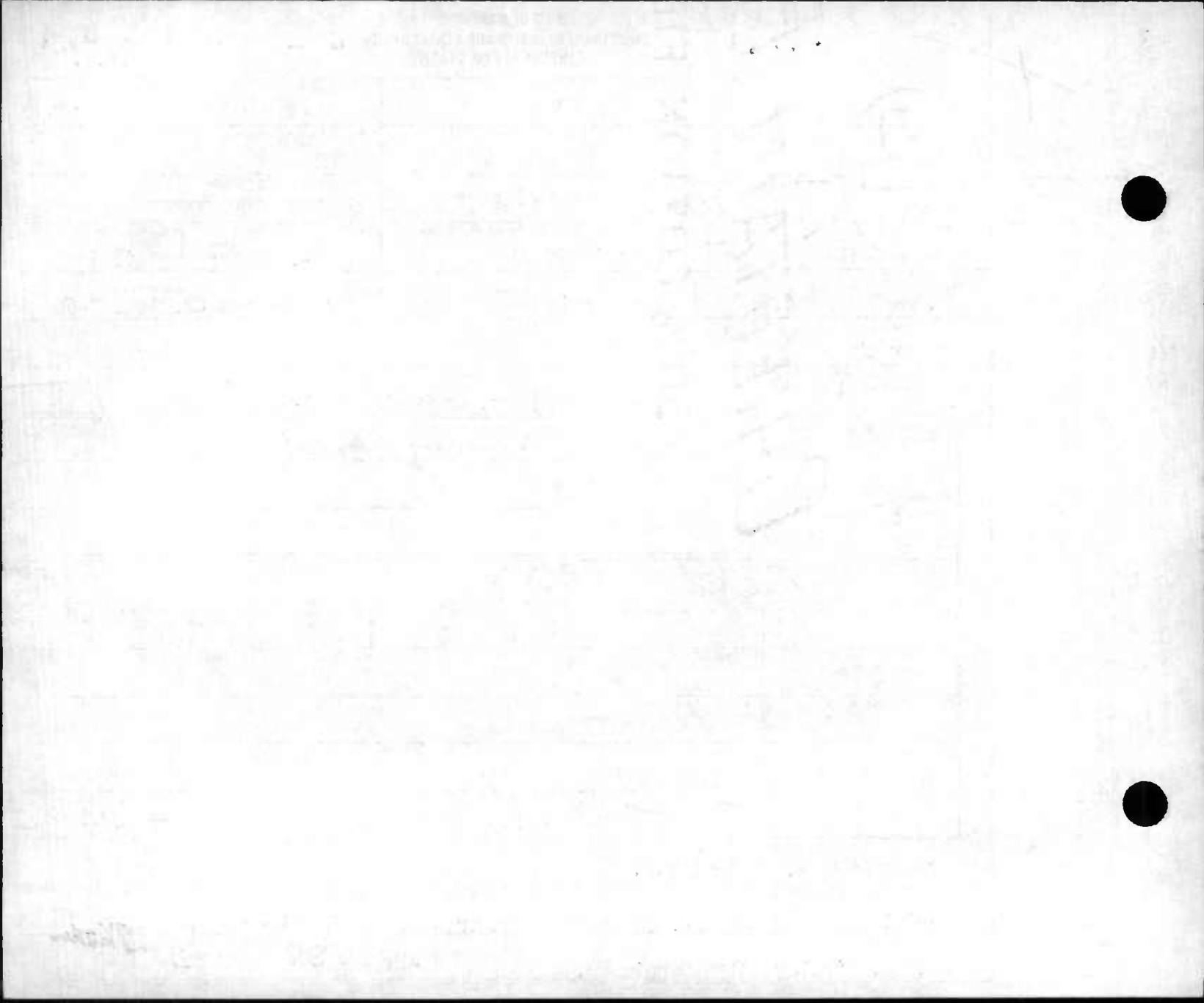
5891 02 998

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 2 0 8 3 8 4 E.S.T.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
FREDERICK H. FAHLKE						APRIL 24, 1982			5:46 A			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male		White		July 30, 1900			81			MONTHS DAYS HOURS MIN.		
7e. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Germany		U.S.					ANNE ARUNDEL COUNTY			MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
GLEN BURNIE		NORTH ARUNDEL HOSPITAL		Const. Worker			Building					
13a. STATE MD.		13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6670 Roberts Ct. Apt. C-59				
14. FATHER'S NAME FIRST Frederick		MIDDLE Fahlke		15. MOTHER'S MAIDEN NAME FIRST Johanna		MIDDLE Zimmer		LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT 218-03-3133		ADDRESS Mrs. Catherine Fahlke same as 13						
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Pulmonary Arrest</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
4215 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b), DUE TO, OR AS A CONSEQUENCE OF (c), DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Arteriosclerosis Legis m</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Devin</i>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/24/82						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHACKUMKAL V. CYRIAC, M.D.		22e. ADDRESS 7445-A FURNACE BRANCH ROAD GLEN BURNIE, MARYLAND 21061										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 27 Apr. 82		23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer Cem.		23d. LOCATION CITY OR TOWN Baltimore		23e. COUNTY MD				
24. FUNERAL DIRECTOR NAME James S. Kirkley Glen Burnie MD.						25a. DATE REC'D. BY REGISTRAR APR 26 1982 James Kirkley		25b. REGISTRATION NO.				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 0 8 3 8 5	
												REG. NO.	
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			George Joseph Faro						April 22, 1982			~6PM	
3 SEX			4 RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male			White			Mar. 12, 1920			62 yrs				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			10a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Md.			USA						A.A.Co. Glen Burnie, MD.			10b. KIND OF BUSINESS OR INDUSTRY Md. Drydock	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Glen Burnie			North Arundel Hospital			Crane operator							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS	
Maryland			A.A.Co.			Glen Burnie						1145 Catch Harbor, Pasadena, Md.	
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Joseph			Faro			Virginia						Reina 2-	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
Yes			W.W.2			218-03-8794			Mrs. Ruth Faro.			Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ATRIOGRAPHIC CARDIOVASCULAR DISEASE</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4148 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>WITH HISTORY OF STROKE AND HTN</i> (c) <i>MYOCARDIAL INFARCTION</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>HYPERTENSION, CONGESTIVE HEART FAILURE, CIGARETTE SMOKER</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) this hospital attended the deceased from _____, 19 _____, to _____, 19 _____, that (we) last saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.													
22b. SIGNATURE <i>Albin O. Kuhn</i>			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4/23/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albin O. Kuhn, II			22e. ADDRESS 1001 PINE HTS. AVE. BALTIMORE MD 21209										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/27/1982			23c. NAME OF CEMETERY OR CREMATORIAL Crownsville Vets. Cemetery			23d. LOCATION CITY OR TOWN Crownsville Anne Arundel Md.				
24. FUNERAL DIRECTOR McCurley Funeral Home, Mt. & Rockneck Rds. Pasadena						25a. DATE REC'D. BY REGISTRAR APR 29 1982			25b. REGISTRAR'S SIGNATURE <i>James J. Martin</i>				

1982.02.20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 82 08386
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
			Curtis (NMN) Fee			April 20, 1982						7:30 AM
3. SEX			4. RACE		5. DATE OF BIRTH	6. AGE [IN YEARS LAST BIRTHDAY]			IF UNDER 1 YEAR			7b. HOUR
Male			White		Aug. 7, 1912	69			MONTHS DAYS			7 AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS			
VIRGINIA			USA.			Anne Arundel MD.			MONTHS DAYS			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Annapolis			Anne Arundel Gen. Hosp		ENGINEER USGov.			POWER PLANT				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13e. STREET ADDRESS				
Md.			A. A.		Annapolis			Rt. 9, 1226 Mt. Pleasant Dr.				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			ADDRESS			
Jerry					Fee	Eliza			Same as #13			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			LAST				
No			226-16-2027		Martha G. Fee			21401				
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) LUNG CARCINOMA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH AT LEAST 1 YEAR												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)												
DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a PRESUMED PELLORATED PEPTIC ULCER												
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
—						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 4-14-1982 to 4-20-1982, that (I) (we) last saw the deceased alive on 4-19-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)									4-20-82			
ANTONIO L. KISON												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			April 22, 1982		Church of God			Gambrills A.A. MD				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
John M. Taylor & Sons Annapolis, MD						APR 22 1982			Anne J. Taylor			

10

to obtain such
such media between such and the main stage
of development as to fit the ~~stage~~ ~~stage~~ ~~stage~~ ~~stage~~ ~~stage~~ ~~stage~~ ~~stage~~

such

such

such

such



such

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 3 8 1
										REG. NO.
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		MIDDLE		2. DATE OF DEATH MONTH DAY YEAR		2b. HOUR		
		Glennie		B		4-15-82		8 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		
Female		White		4 06 04		78		YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		IF UNDER 24 HRS HOURS MIN		
Virginia		U.S.A.				Anne Arundel Co.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Millersville Md.		Kingswood Manor		Homemaker		-				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		
Md.		Anne Arundel		Severn		YES		7822 Stateman St.		
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		
Egbert				Campbell		Mary		LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
no		229-24-5166		Stella Duty (dghtr)		same address		Immed.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>										
<u>4292</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic cardiovascular disease</u> Years										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Cerebrovascular disease hypertension</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
-		-				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. - 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		-		-		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>12-15-1981</u> to <u>4-15-1982</u> , that (I) (we) last saw the deceased alive on <u>4-24-1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										
22b. SIGNATURE <u>IE Kaplan</u>		22c. DEGREE <u>M.D.</u>		22d. ADDRESS <u>Oakwood PROF BUILD. Glen Burnie</u>		22e. DATE SIGNED <u>4/15/82</u>				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>IE Kaplan, MD</u>		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22g. ADDRESS		22h. DATE REC'D. BY REGISTRAR <u>APR 20 1982</u>		22i. REGISTRAR'S SIGNATURE <u>John J. Smith</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/19/82		23c. NAME OF CEMETERY OR CREMATORIAL Parkwood		23d. LOCATION CITY OR TOWN Baltimore		COUNTY STATE Md.		
24. FUNERAL DIRECTOR NAME St. Luke's Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213		24b. DATE REC'D. BY REGISTRAR <u>APR 20 1982</u>		24c. REGISTRAR'S SIGNATURE <u>John J. Smith</u>						

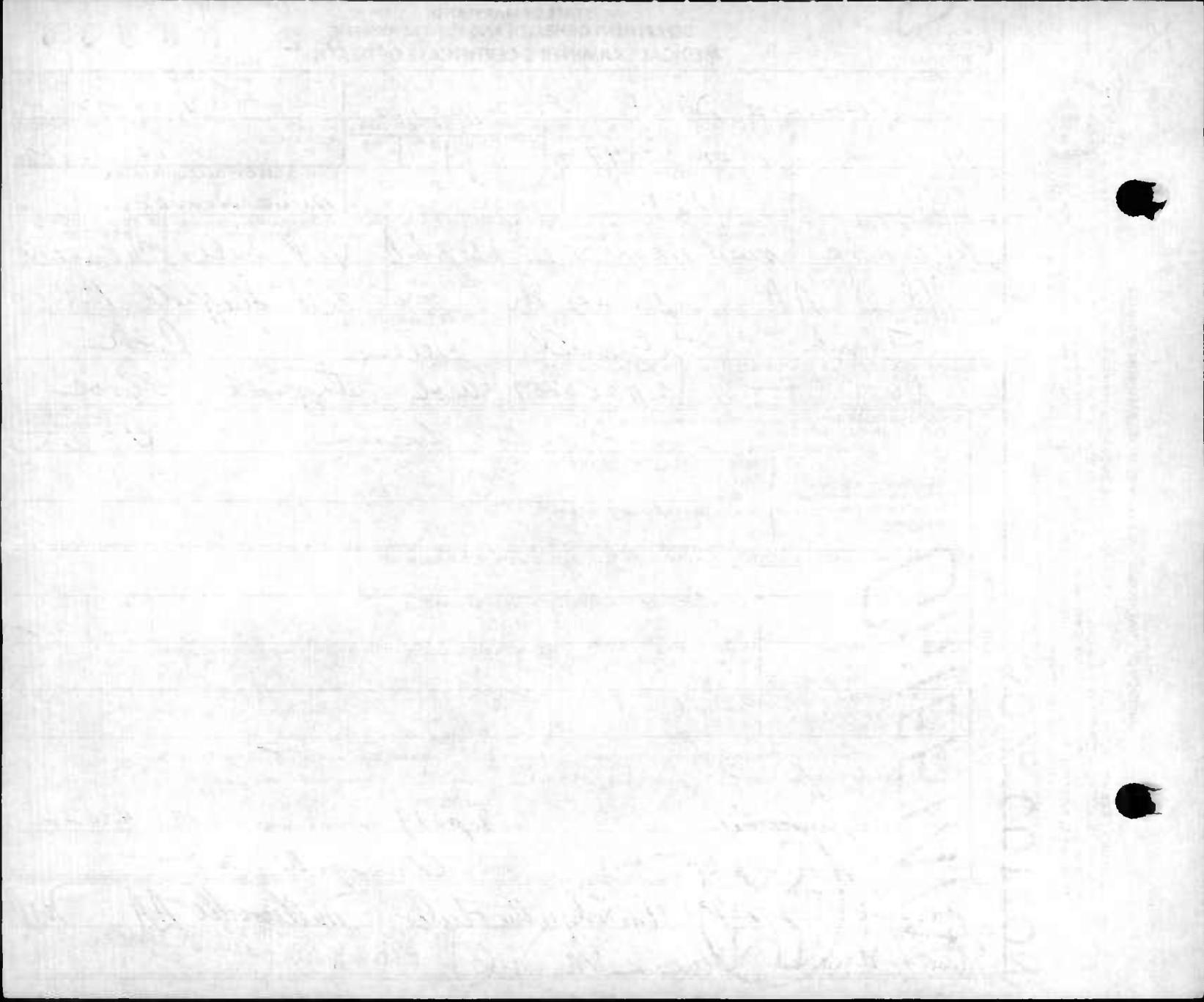
John R. Smith SSB US AR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8 2 0 8 3 8 8				
1- STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR				
			<i>FRANCIS DAVID FITZGERALD</i>						<input checked="" type="checkbox"/> MONTH DAY YEAR <i>4 24 1982</i>			P M				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD			2d. HOUR	
M		W		<i>1 27 35</i>		<i>47</i>						<i>4 24 1982</i>			P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH				
<i>Pa</i>			<i>USA</i>			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			<i>Baltimore</i>			<i>Bellevue</i>				
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION / TYPE OF WORK FOR MOST OF WORKING LIFE				12b. KIND OF BUSINESS OR INDUSTRY				13a. STATE				
<i>North Arundel Hospital</i>				<i>V.P. Sales Chemical</i>								<i>Md</i>				
13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS				
<i>AA</i>				<i>Severna Park</i>				<input checked="" type="checkbox"/>				<i>378 Sheffield Rd</i>				
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				17. INFORMANT ADDRESS				
<i>Frank</i>				<i>Helen Rock</i>				<i>No</i>				<i>Carol Fitzgerald - Above</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary artery disease</i> DUE TO, OR AS A CONSEQUENCE OF 4149 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i> sudden</i>				
(b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?				
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																
ACTUAL SIGNATURE		TITLE (SPECIFY) <i>E. B. Blandford</i> M.D. <i>Deputy</i> MEDICAL EXAMINER														
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS <i>Annapolis, Md</i>														
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ESTABLISHMENT		23d. LOCATION CITY OR STATE		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE						
<i>Funeral</i>		<i>4/28/82</i>		<i>Our Lady of the Falls</i>		<i>Millennium Inn</i>		<i>APR 29 1982</i>		<i>Anne J.</i>						
24. FUNERAL DIRECTOR NAME		ADDRESS														
<i>Paul Blandford</i>		<i>Severna Park Md</i>														
DHMH - 17 (VR A15 ME (5))																
15M 7/77																

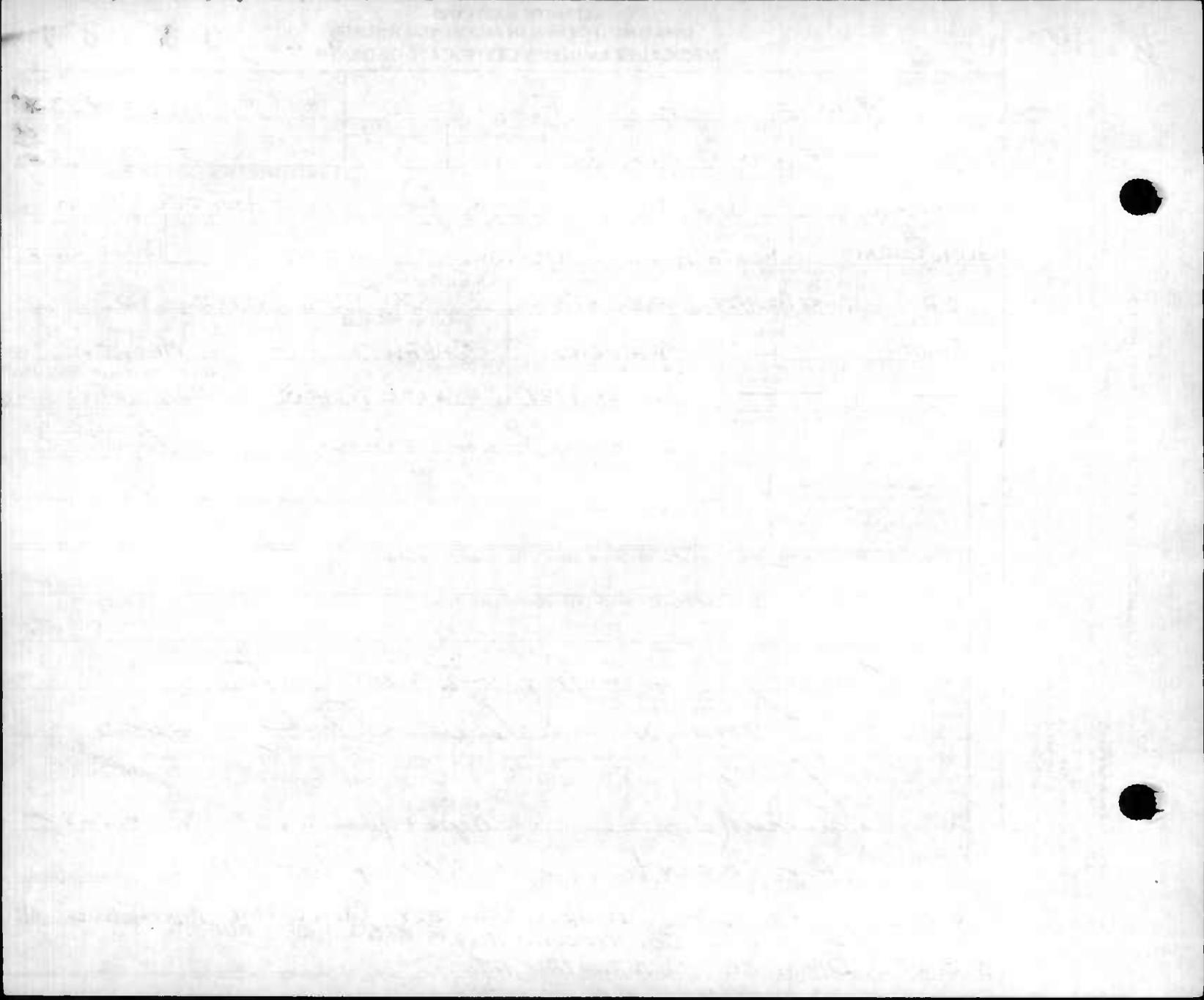


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 24 HOURS OF DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8208389			
1- STATE REGISTRAR				2a. DATE KNOWN OF ESTI- DEATH MATED								2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		<input type="checkbox"/>	MONTH	DAY	YEAR	2b. HOUR	
MARIE A. FLEETWOOD										<input type="checkbox"/>	APRIL 13, 1982	3:58 AM			
1. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD									
FEMALE	WHITE	JULY 17 1893	88 yrs.			+ 13, 1982 3 AM									
a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND				U. S. A.								ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
GLEN BURNIE				NORTH ARUNDEL HOSPITAL				12a. RETIRED				12b. POLAND KATZ			
13a. STATE MD.				13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN SEVERNA PARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 735 CYPRESS RD.			
14. FATHER'S NAME JOHN				MIDDLE L.		LAST MATHEWS		15. MOTHER'S MAIDEN NAME SARAH				16. ADDRESS 610 KENSINGTON AVE SEVERNA PARK, 21144			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO. 212-28-9738				17. INFORMANT MARGRET L. NICHOLS				18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Dudden			
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4151 Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause lost.				DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 4-12 1982				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fleet N.A.C. Center							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) missing name				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Severna Park 21144							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>E. L. INGRAM</i> TITLE (SPECIFY) M.D. Dep't + q MEDICAL EXAMINER DATE SIGNED 4-4-82															
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS Avanspr 115 - n o											
23a. BURIAL, CREMATION, REMOVAL (SPECIES)				23b. DATE APRIL 16, 1982				23c. NAME OF CEMETERY OR CREMATORIAL GLEN HAVEN CEMETERY				23d. LOCATION CITY OR TOWN GLEN BURNIE			
24. FUNERAL DIRECTOR NAME ROBERT S. BARRANCO				ADDRESS 501 RITCHIE Hwy SEVERNA PARK, MD. 21146				25a. DATE ISSUED BY REGISTRAR APRIL 16, 1982				25b. SIGNATURE <i>Anne Arundel Co. Health Dept.</i>			

BP

DHMH - 17
(VR A15 M 5)
15M 7/76



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 3 9 0			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
Frances M. Frank						April 28, 1982							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
Female		White		August 27 1894			87						
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.						
Maryland		U.S.A.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hanover		Home - 7401 Locust Dr.								Homemaker			
13a. STATE Md.		13b. COUNTY A.A. Co.		13c. CITY OR TOWN Hanover			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7401 Locust Dr. (21076)				
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME Wilhelmina		MIDDLE		LAST		
Joseph				Nueslein							Weinkam		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT			17. ADDRESS						
NO		214 40 4778		Georgette Frank same as 13 e									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intractable Congenital Ht Failure</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 moil													
4295 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b), (c) DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4-21-82</u> , to <u>4-26-82</u> , in <u>Baltimore</u> , MD, the (I) (we) last saw the deceased alive on <u>4-21-82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (not) (let) (see) the body after death.													
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>4/30/82</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <u>Mrs. REARCMAN m</u>			22f. ADDRESS <u>5400 Old Court Rd</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial		5/1/82		Holy Redeemer Cem			Baltimore, Maryland						
24. FUNERAL DIRECTOR NAME George J. Gonce		ADDRESS 4001 Ritchie Hwy			25a. DATE REC'D. BY REGISTRAR MAY 3 1982			25b. REGISTRAR'S SIGNATURE <u>Frances Jean Hartman</u>					

James SHERMAN and others, Plaintiff-Appellants,
v. The City of NEW YORK, Defendant-Appellee.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.																	
1. FOR STATE REGISTRAR			8 2 0 8 3 9 1																										
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR											
Annie K. Frano												4-6-82					7:38	M											
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS														
female			White			MON. DAY			83			MONTHS DAYS			HOURS MIN.														
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY														
Virginia			USA						Anne Arundel MD.			housewife																	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Annapolis			AA General Hospital									Md.			A.A.			Woodland			Bch.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			450 Cedar Grove Rd		
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS					
Andrew Jacob Kerns												Elizabeth Elkins			no			213 30 7287			Lucille Blaisdell, #13								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart failure</u>														
															DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterio sclerotic Heart Disease</u>														
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Osteoarthritis.</u>																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?														
												YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)																							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE																							
22a. I certify that (I) (this hospital) attended the deceased from <u>March 7</u> , 19 <u>82</u> , to <u> </u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>March 7</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>Well B. Freedley</u> DEGREE <u>MD</u>															ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>4-7-82</u>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS																										
134 Owingsville Road			134 Owingsville Rd. West River 20778																										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-9-82			23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest			23d. LOCATION CITY OR TOWN Annapolis			COUNTY AACO Ma			STATE														
24. FUNERAL DIRECTOR NAME Hardesty FH, 12 Ridgely Ave; Annapolis, Ma. 21401									25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE																	
									APR 8 1982			<u>James J. Master</u>																	

Family history

and old photo albums

and old writing

and old

Memories

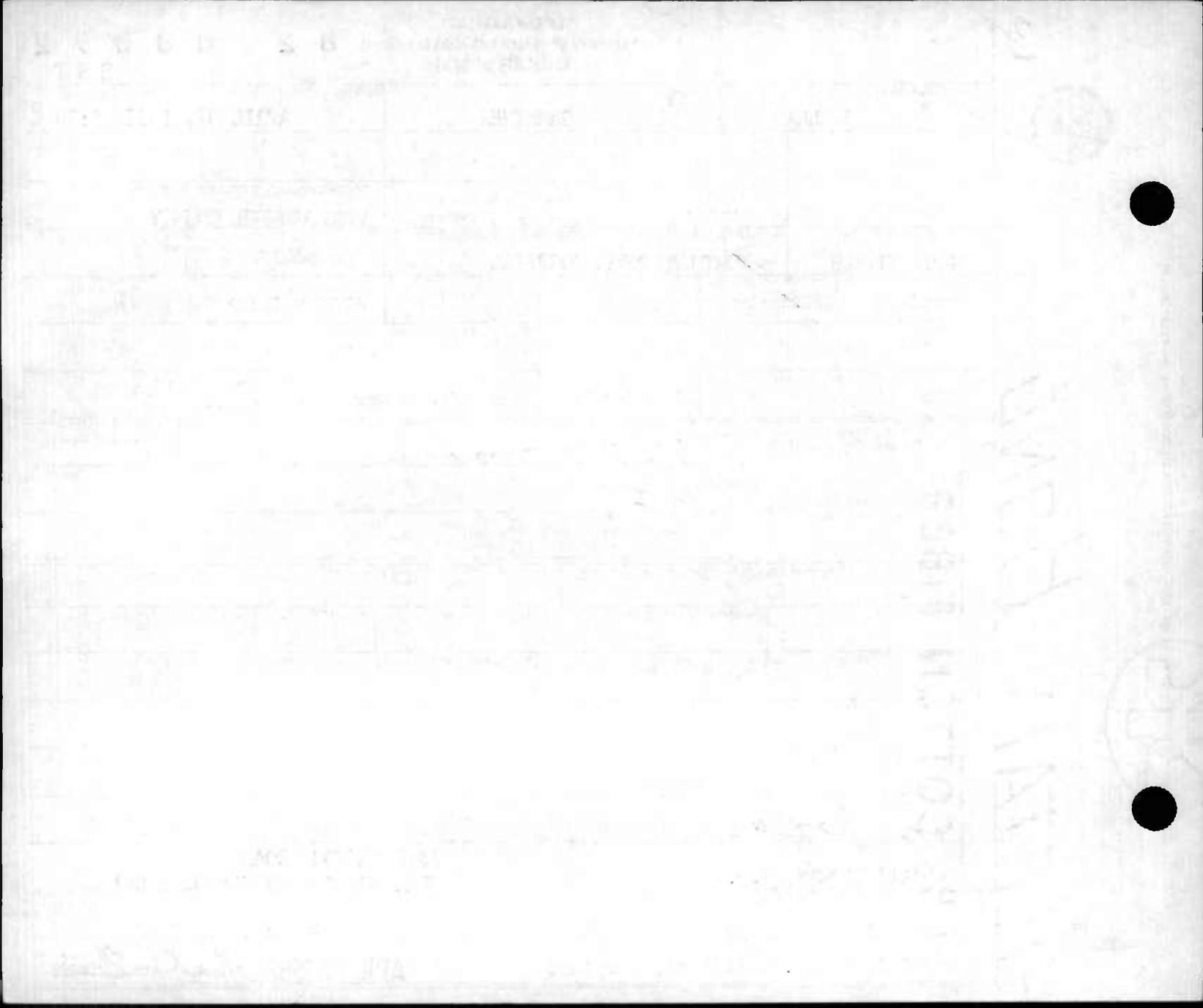
memories from old photo albums

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8208392 EST
1. DECEASED NAME	FIRST STELLA	MIDDLE	LAST GAERTNER	2a DATE OF DEATH APRIL 07, 1982	2b. HOUR 2:30 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH DEC 6, 1900	6. AGE (IN YEARS LAST BIRTHDAY) 81	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN Maryland)	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Towson	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 6706 Selkirk Rd	
14. FATHER'S NAME ? FIRST	MIDDLE Kress	LAST	15. MOTHER'S MAIDEN NAME Unk		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 215-03-1386D	17. INFORMANT Mrs Rita R Gorschboth	ADDRESS 730 Milldam Rd Towson, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congular arrest</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>M.E.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Marc Kaplan</u>	22c. DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	DATE SIGNED 4/17/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARC KAPLAN, M.D.	22e. ADDRESS 7845 OAKWOOD ROAD GLEN BURNIE, MARYLAND, 21061				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/10/82	23c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn	23d. LOCATION CITY OR TOWN Baltimore, Maryland	23e. COUNTY	STATE
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland	ADDRESS	25a. DATE REC'D. BY REGISTRAR APR 12 1982	25b. REGISTRAR'S SIGNATURE <u>James J. Ruck</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or, Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												82 08393			
												REG. NO.			
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			ELLA Maude GESNER						April 22 1982			A. M.			
II. SEX			4 RACE			5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR IF UNDER 24 HRS			
Female			White			May 13, 1894			81			MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.			
MD			USA						Anne Arundel						
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12e USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Annapolis			Annapolis Convalescent Center			Ret. Telephone Op.			Civil Service						
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
MD			A.A.			Annapolis			505 1st Street 21403						
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			17 INFORMANT ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS HEART DIS. DUE TO, OR AS A CONSEQUENCE OF (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 100 MINUTES			
Samuel Stevens			Alice Evelyn Small									15 yrs			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17 INFORMANT ADDRESS									
NO			—			Evelyn Small									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CEREBRAL ARTERIOSCLEROSIS															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 21)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) this hospital attended the deceased from 4-13 1982 to 4-22 1982, that (I/we) lost saw the deceased alive on above (I) was (we) did (I) did not view the body after death.												22c. DATE SIGNED 4/22/82			
22b. SIGNATURE Edward S. Beck, M.D.			22d. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22e. ADDRESS 1616 Forest Drive, Annapolis, MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE April 24, 1982			23c. NAME OF CEMETERY OR CREMATORIALy Cedar Bluff			23d. LOCATION CITY OR TOWN Annapolis			STATE A.R. MD			
24 FUNERAL DIRECTOR NAME John M. Taylor & Sons, Annapolis, MD			25a. DATE REC'D. BY REGISTRAR APR 27 1982			25b. REGISTRAR'S SIGNATURE Frank J.									

30

18. 1881. July 1st. 1881.
Lobelia sp. 2000 ft. -
Cordyline sp. 1800 ft.
Pandanus sp. 1800 ft.
Psychotria sp. 1800 ft.

Psychotria sp. 1800 ft.
Psychotria sp. 1800 ft.
Psychotria sp. 1800 ft.
Psychotria sp. 1800 ft.
Psychotria sp. 1800 ft.
Psychotria sp. 1800 ft.
Psychotria sp. 1800 ft.
Psychotria sp. 1800 ft.

Psychotria sp. 1800 ft.
Psychotria sp. 1800 ft.
Psychotria sp. 1800 ft.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 2 FOR YOUR USES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSPORT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- STATE 6-4-82 AL REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8208394				
1. DECEASED NAME (TYPE OR PRINT)		FIRST Ernest (nmn)			MIDDLE Gillis			LAST			2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH 4 OF ESTL. DEATH MATED <input type="checkbox"/> DAY 19 YEAR 1982		2b. HOUR PM			
3. SEX Male		4. RACE White			5. DATE OF BIRTH Nov. 21, 31			6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.			IF UNDER 1 YR. MONTHS		IF UNDER 24 HRS. DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD.			2c. DATE PRONOUNCED DEAD 4 19 82		2d. HOUR PM			
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 404 Eugenia Avenue			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pressman (Ret.)			12b. KIND OF BUSINESS Amer. Can Company								
13a. STATE Maryland		13b. COUNTY Anne Arundel			13c. CITY OR TOWN Glen Burnie			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 404 Eugenia Avenue					
14. FATHER'S NAME FIRST Walter		MIDDLE G.			LAST Gillis			15. MOTHER'S MAIDEN NAME FIRST Holly			MIDDLE			LAST Engels		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A			16c. TIME OF INJURY HOUR A.M. P.M.			17. INFORMANT (Wife) Mrs. Virginia L. Gillis			ADDRESS Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9554 IMMEDIATE CAUSE (a) <i>Gun shot wound chest & heart</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i>Gun shot wound chest & heart</i>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			19c. TIME OF INJURY HOUR A.M. P.M.			19d. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Gun Shot wound chest & abdomen			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home			21c. LOCATION STREET 404 Eugenia Ave CITY OR TOWN Glen Burnie COUNTY AA, STATE MD											
21d. INJURY OCCURRED WHILE NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. TIME OF INJURY DAY 19			21f. DATE SIGNED 7-19-82											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>E.L. Witthardt</i>																
EXAMINER'S NAME (TYPE OR PRINT) E.L. Witthardt		ADDRESS <i>Glen Burnie, MD</i>			TITLE (SPECIFY) Deputy MEDICAL EXAMINER											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 23, 1982			23c. NAME OF CEMETERY OR CRÉMATORIUM Glen Haven Mem. Park			23d. LOCATION CITY OR TOWN Glen Burnie, A.A. MD								
24. FUNERAL DIRECTOR NAME <i>Singleton</i>		ADDRESS Glen Burnie, Singleton Funeral Home MD.			25a. DATE REC'D. BY REGISTRAR APR 22 1982			25b. DATE REC'D. BY REGISTRAR APR 22 1982								
BP _____																
DHMH - 17 (VR A15 ME (5)) 15M 7/76																

California 8800 ft

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be continued if necessary.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8208395				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
SAM ORR GILMER, Jr.						4-25-82						8:46 pm		
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
M			WHITE	MONTH	DAY	YEAR	66			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD		
N.C.			USA						A.A.C.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR (TYPE OF WORK FOR MOST OF WORKING LIFE)					
Glen Burnie			NORTH ARUNDEL Hos. ER			PUBLIC HEALTH SOUT.								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
Md			AA			Severna Pt						204 Holland Rd		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME								
Sam Orr Gilmer Jr.						Manlee Casoll								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Yes			447186918			Forth Gilmer - Alone						3+ years		
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of prostate</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>with generalized metastases</u>														
(c) DUE TO, OR AS A CONSEQUENCE OF														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
10-5-81			Bilateral orchectomy			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2-10 1958 to 4-25 1982, that (I) (we) lost sow the deceased alive on 4-19 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>John D. Young, M.D.</u> DEGREE														
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f. DATE SIGNED					
JOHN D. YOUNG, M.D.			UNIV. OF MD. HOSP., BALTO., 21201						4-26-82					
23a. BURIAL, Cremation, Removal OFFICE			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNTIES STATE		
Funeral			4/28/82			Mt. Vernon Cem. Crownsville			Md					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
John D. Young, M.D.			Severna Pt			APR 29 1982			John J. Gantman					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use at the burial/transtil permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours along with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8208396	
											REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Doris Williams Glenn						04 22 82							
3. SEX		F	4. RACE		Negro	5. DATE OF BIRTH		MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		
7b. BIRTHPLACE COUNTRY		Md	7b. CITIZEN OF WHAT COUNTRY?		U.S.A.	8. MARRIED		<input checked="" type="checkbox"/>	NEVER MARRIED	<input type="checkbox"/>	IF UNDER 1 YEAR MONTHS DAYS		
10. CITY OR TOWN OF DEATH		Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		Anne Arundel Gen'l Hosp	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST WORKING LIFE)		Food Service				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE		Md	13b. COUNTY		A.I.A. ANNAPOLIS	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS		MD.
14. FATHER'S NAME		Joseph Chase				15. MOTHER'S MAIDEN NAME		Getrude GALLAWAY				LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF UNKNOWN)		No	16b. SOCIAL SECURITY NO		216-36-2152	17. INFORMANT		Waverly Glenn Same As 13e				ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1749 Breast carcinoma												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Hypertension													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 22 to 4/22 19 82, that (we) last saw the deceased alive on 4/21 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Joseph N. Friend, M.D.		DEGREE						22c. DATE SIGNED 4/22/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph N. Friend		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22e. ADDRESS 205 Ridgeley Ave Annapolis, Md.									
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 27-82		23c. NAME OF CEMETERY OR CREMATORIAL Pine Lawn		23d. LOCATION CITY OR TOWN ANNAPOLIS A.I.A. MD							
24. FUNERAL DIRECTOR C.E. Hicks III ANNAPOLES-MD				25a. DATE REC'D. BY REGISTRAR APR 27 1982		25b. REGISTRAR'S SIGNATURE Thomas J. Norton							

smallish

A.2 H. LM

55.11.92 best

2010-09-19 1917-3811 x elegant A.2 bM
jewell's short-tail 3rd tail tert.
2010-09-19 1917-3812 pluvialis 2nd-3rd

bM A.2 elegant and mlt. colored barred
bM - 2nd-3rd tail tert. 2nd-3rd



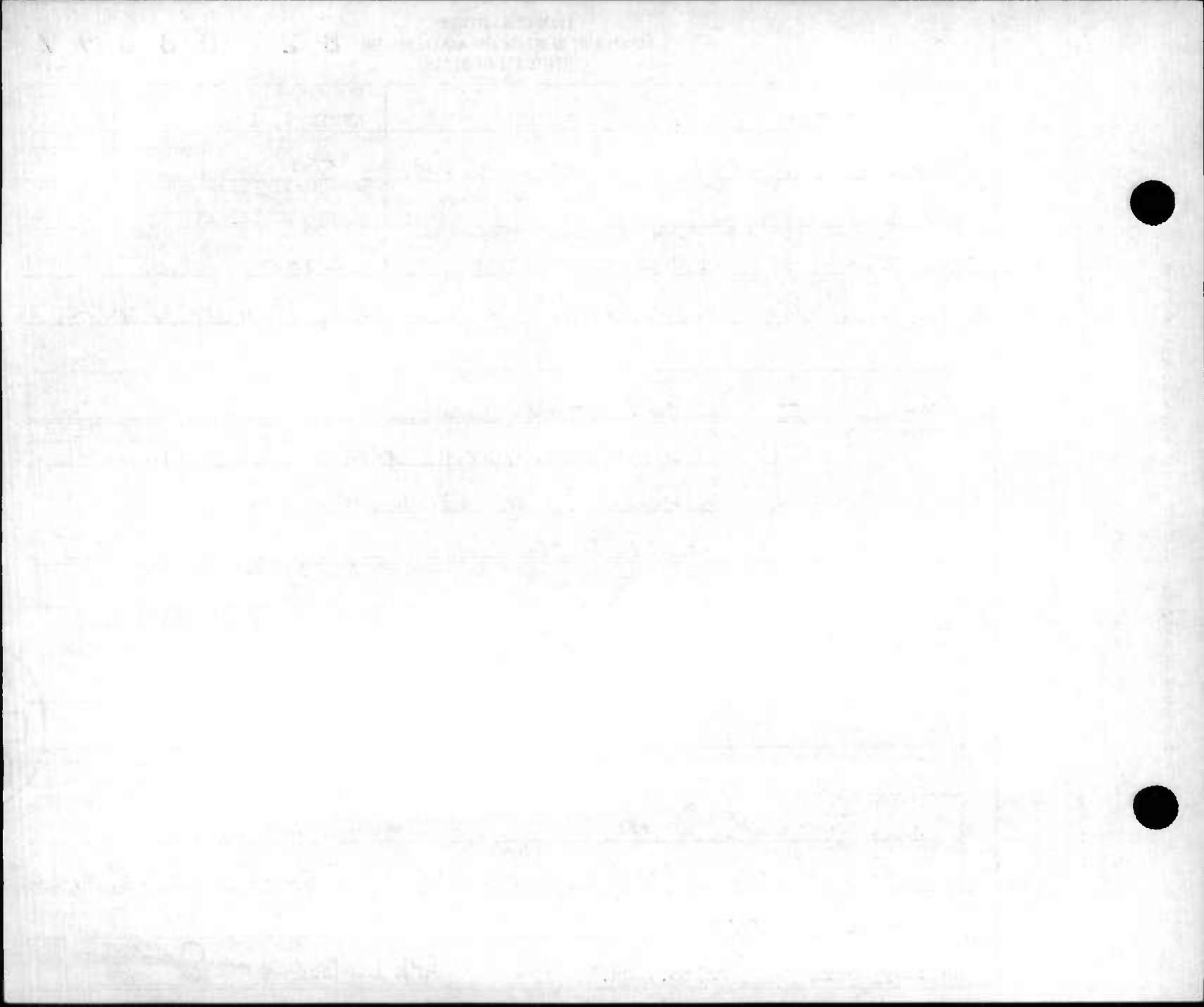
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do my best.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 3 9 1							
										REG. NO. EST							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
MARION V. GOLDEN						APRIL 6, 1982						6:40 P.M.					
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
Female			White		04 05 22		59			YEARS	MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH							
VIRGINIA			USA				ANNE ARUNDEL COUNTY MD.			GLEN BURNIE							
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)							
NORTH ARUNDEL HOSPITAL										12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland										13b. COUNTY USA		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 401 Summer Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. UNK - - -			17. INFORMANT 227 305162			ADDRESS								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immed.							
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis + Rheumatic Heart Dis</u>										Years							
(c) <u>Atherosclerosis</u>										Years							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>COPD Cancer of Colon</u>																	
19a. DATE OF OPERATION 3/30/81			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer of Colon			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED							
THE SIGNATURE <u>J E Kaplan MD</u>										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J E Kaplan MD</u>			22e. ADDRESS <u>Oakwood PROF BLDG. Glen Burnie</u>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 4/7/82			23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN COUNTY STATE			23d. LOCATION CITY OR TOWN COUNTY STATE								
24. FUNERAL DIRECTOR NAME Anatomy Board										25a. DATE REC'D. BY REGISTRAR APR 15 1982							
ADDRESS Balto., Md.										REGISTRAR'S SIGNATURE <u>Shane J. Muller</u>							

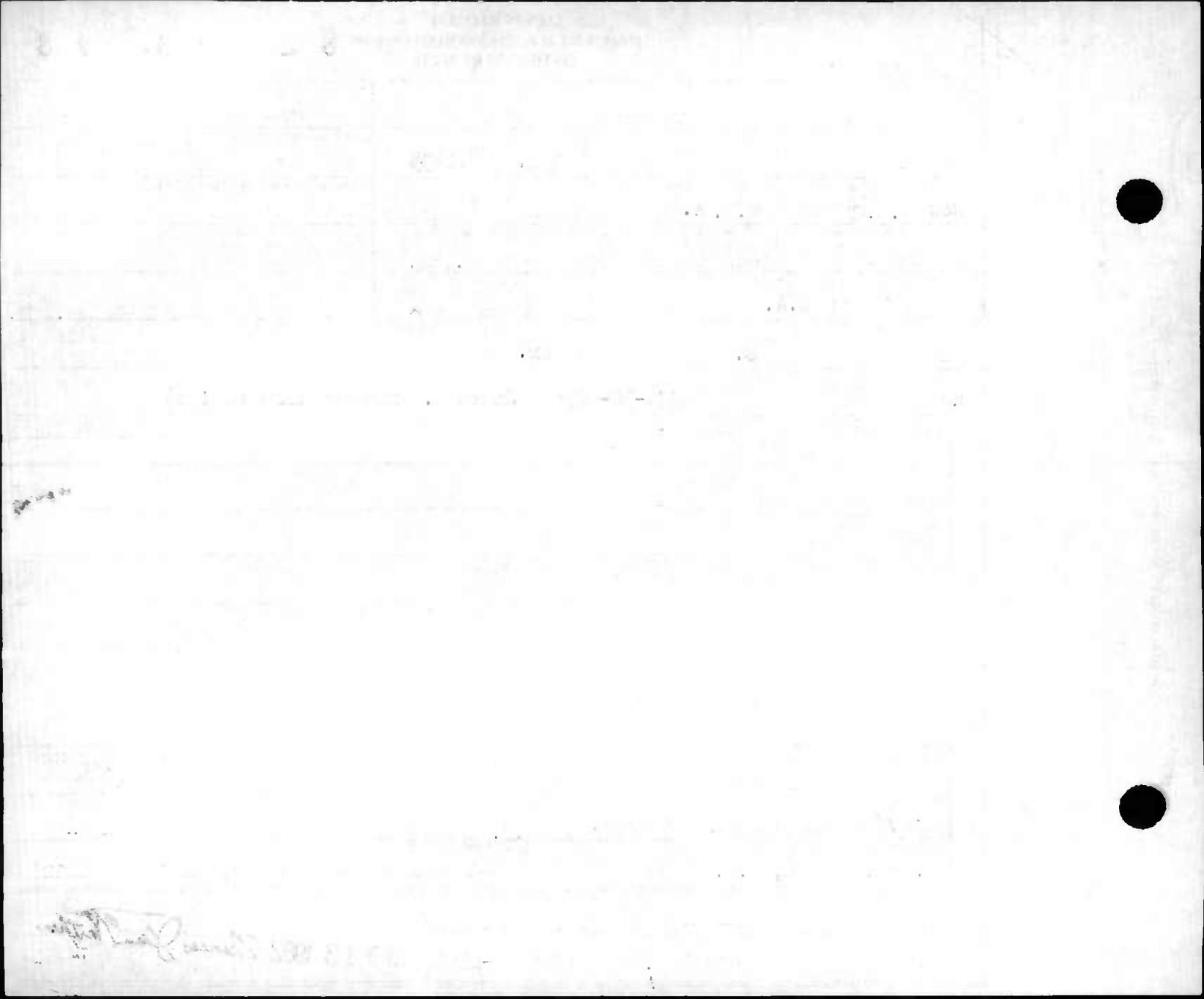


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it should be detached for use as the burial/transit permit. Then please remove carbon paper with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	2	0	8	3	9	8
										REG. NO.						
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR							
DECEASED NAME (TYPE OR PRINT)			LAST			04-10-82			12:25 PM							
FLORENCE ELEANOR GRANGER																
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH Nov. 8, 1934		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel										
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 409 TOWNSEND AVENUE-BALTO., MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE MARYLAND		13b. COUNTY A.A.		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 409 TOWNSEND AVENUE-BALTO., MD.							
14. FATHER'S NAME FIRST John		MIDDLE S.		LAST KITCHNER Sr.		15. MOTHER'S MAIDEN NAME FIRST MARY			MIDDLE WATSON			21225				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. ADDRESS 220-30-5756		17. INFORMANT James D. Granger (same as 13e)			ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1919 IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) GLIOBLASTOMA OF THE BRAIN DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) XXXXXX attended the deceased from APRIL 30, 1981 , to APRIL 10, 1982 , that (I) XX lost saw the deceased alive on APRIL 9, 1982 , and that in (my) XX opinion death occurred on the date and hour and from the causes stated above, (I) XX did not view the body after death.																
22b. SIGNATURE K. Dharmasena M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 04-12-82						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. DHARMASEN , M.D.		22e. ADDRESS #8-16th AVENUE-BALTIMORE, MARYLAND 21225														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 04-13-82		23c. NAME OF CEMETERY OR CREMATORIAL HOLY CROSS CEMETERY		23d. LOCATION BALTIMORE, MARYLAND 21225		23e. LOCATION 6020 GOVERNOR RUTHERFORD								
24. FUNERAL DIRECTOR NAME GONCE		ADDRESS FUNERAL HOME-4001 RITCHIE HIGHWAY-21225		25a. DATE REC'D. BY RECORDING OFFICER APR 13 1982												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be informed at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8208399
										REG. NO. EDT
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
AGNES MARIE GRIMES						APRIL 29, 1982				6:00 P.M.
3. SEX Female			4. RACE White	5. DATE OF BIRTH Dec. 20 1910	6. AGE (IN YEARS LAST BIRTHDAY) 71	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH GLEN BURNIE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL			12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY A.A.	14. CITY OR TOWN Pasadena	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	14. STREET ADDRESS 78 Johnson Rd. (21122)				
14. FATHER'S NAME William			B. Crothers	15. MOTHER'S MAIDEN NAME Rose	16. ADDRESS Hessler					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 212-74-1829	17. INFORMANT James B. Grimes (same as 13e)						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 acute inferior myocardial									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) Infarction w/o cardiac arrhythmia							
			DUE TO, OR AS A CONSEQUENCE OF (c) Stroke							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above, (I) (we) did (did not) view the body afterwards.			22b. DATE 19	22c. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated						
22d. SIGNATURE			22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22f. DATE SIGNED 4/30/82						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DALJIT S. SAWHNEY, M.D.			22e. ADDRESS 205 Baltimore-Annapolis Blvd. Glen Burnie, Maryland 21061							
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 5/3/82	23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Mem.	23d. LOCATION CITY/TOWN Baltimore	23e. COUNTY Md.				
24. FUNERAL DIRECTOR NAME George J. Gonc F.H. 4001 Ritchie Hwy.			24b. ADDRESS	24c. DATE REC'D. BY REGISTRAR MAY 3 1982	24d. REGISTRAR'S SIGNATURE Frances Jean Hartman					

2025 RELEASE UNDER E.O. 14176

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

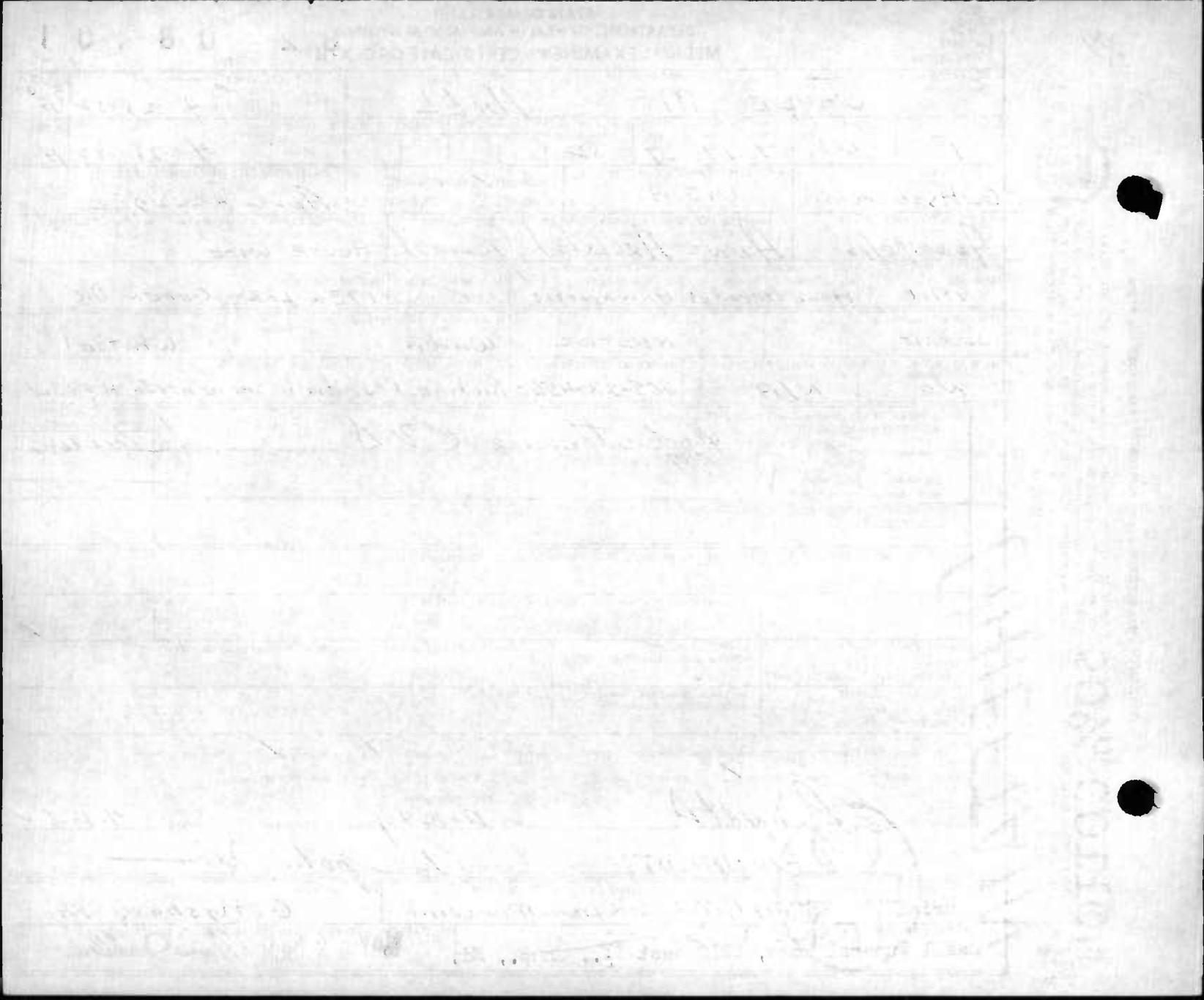
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 0 8 4 0 0 E.S.T.		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
WILLIAM J. GURTSHAW, SR.						APRIL 15, 1982			5:55 A.M.					
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
Male			Caucasian			2- 9- 1896			86 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
New York			U.S.A.											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
GLEN BURNIE			NORTH ARUNDEL HOSPITAL			Turbine Erector G.E. Ret.								
13a. STATE Md.			13b. COUNTY Pr. Geo.			13c. CITY OR TOWN Bowie			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 2236 Hindle La.		
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME								
William			Gurtshaw			Elvira						LAST Wing		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS					
No			108-10-2527			Margaret M. Gurtshaw Same as # 13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Acute Respiratory Failure</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4169 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Severe Emphysema</i> (c) <i>Congestive Heart Failure</i>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (He) attended the deceased from <i>4/17</i> , 19 <i>82</i> , to <i>4/15</i> , 19 <i>82</i> , that (I) (He) last saw the deceased alive on <i>4/14</i> , 19 <i>82</i> , and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.												22c. DATE SIGNED <i>4/15/82</i>		
22b. SIGNATURE <i>Elliott Gorbaty MD</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ELLIOTT GORBATY, M.D.			22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 203 GLEN BURNIE, MARYLAND 21061											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 4-16-82			23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln			23d. LOCATION CITY OR TOWN Brentwood			COUNTRY Pr. Geo. Md.		
24. FUNERAL DIRECTOR NAME Beall Funeral Home ADDRESS 16,000 Annapolis Rd. Bowie, Md.						25a. DATE REC'D. BY REGISTRAR APR 19 1982			25b. REGISTRAR'S SIGNATURE <i>Janice Jan Novak</i>					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. PAGE 4 SHOULD BE FORWARDED TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8208401					
1. DECEASED NAME (TYPE OR PRINT)				FIRST Joyce M				LAST Hall				2a. DATE KNOWN OF ESTI- DEATH MATED					
SEX F		RACE W		5. DATE OF BIRTH MONTH 7 YEAR 1929		6. AGE (IN YEARS LAST BIRTHDAY) 52 yrs.		IF UNDER 1 YR. MONTHS		IF UNDER 24 HRS. DAYS HOURS MIN.		MONTH DAY YEAR		2b. HOUR 5:00 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Gettysburg Pa.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				2c. DATE PRONOUNCED DEAD				2d. HOUR 4:28 AM	
10. CITY OR TOWN OF DEATH Annapolis				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Anne Arundel General				12a. USUAL OCCUPATION (TYPE OF WORK) House wife				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md				13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1732 Long Green Dr							
14. FATHER'S NAME FIRST J. LERICLE				MIDDLE		LAST KELLOGG		15. MOTHER'S MAIDEN NAME Wadsworth		MIDDLE				LAST Whitsell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. N/A				17. INFORMANT Richard J. Hall son as 13a b/t 13c				ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4029 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Fallen					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN		COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER					
ACTUAL SIGNATURE <i>E. Linhardt</i>				EXAMINER'S NAME (TYPE OR PRINT) <i>E. LINHARDT</i>				ADDRESS <i>Annapolis, Md</i>				DATE SIGNED <i>7.26.82</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE May 1, 1982				23c. NAME OF CEMETERY OR CREMATORIAL Oak Lawn Memorial				23d. LOCATION CITY OR TOWN					
24. FUNERAL DIRECTOR <i>Beall Funeral Home, 1212 West St., Annapolis, Md</i>				25a. DATE REC'D. BY REGISTRAR MAY 3 1982				25b. REGISTRAR'S SIGNATURE <i>Anne Arundel</i>									



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PRINT IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												8 2 0 8 4 0 2	REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTIMATED				MONTH	DAY	YEAR	2b. HOUR	
<i>Benson C. HARDESTY</i>			<i>C.</i>	<i>HARDESTY</i>		4	21	1982	P	M				
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD				MONTH	DAY	YEAR	2d. HOUR	
<i>M</i>	<i>w</i>	<i>6 3 24</i>				4	21	1982	P	M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH							
<i>Baltimore, MD</i>		<i>USA</i>					<i>Anne Arundel</i>							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
<i>Glen Burnie</i>		<i>NORTH ARUNDEL Hospital</i>			<i>Self-Employed</i>		<i>Seafood Ind.</i>							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS						
<i>MD</i>		<i>Anne Arundel</i>		<i>Glen Burnie</i>		YES <input checked="" type="checkbox"/>		<i>605 Delaware Avenue</i>						
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		V. LAST						
<i>Benson C. Hardesty, Sr.</i>						<i>Emma</i>		<i>Weems</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS							
Yes		<i>WW II</i>			<i>216-14-8536</i>		<i>Betty L. Hardesty, Same as 13</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <i>Bennie Turner</i> 2396 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												YES <input checked="" type="checkbox"/>		
DUE TO, OR AS A CONSEQUENCE OF (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												TITLE (SPECIFY) <i>Medical Examiner</i>		
ACTUAL SIGNATURE <i>Elinhardt</i>												M.D. <i>Deputy</i> MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			DATE SIGNED <i>4.21.82</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 24 April 82			23c. NAME OF CEMETERY OR CREMATORIUM Lorraine Park			23d. LOCATION CITY OR TOWN Woodlawn			COUNTY Baltimore		STATE MD
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD			ADDRESS			25a. DATE REC'D. BY REGISTRAR APR 23 1982			25b. REGISTRAR'S SIGNATURE <i>James S. Kirkley</i>					

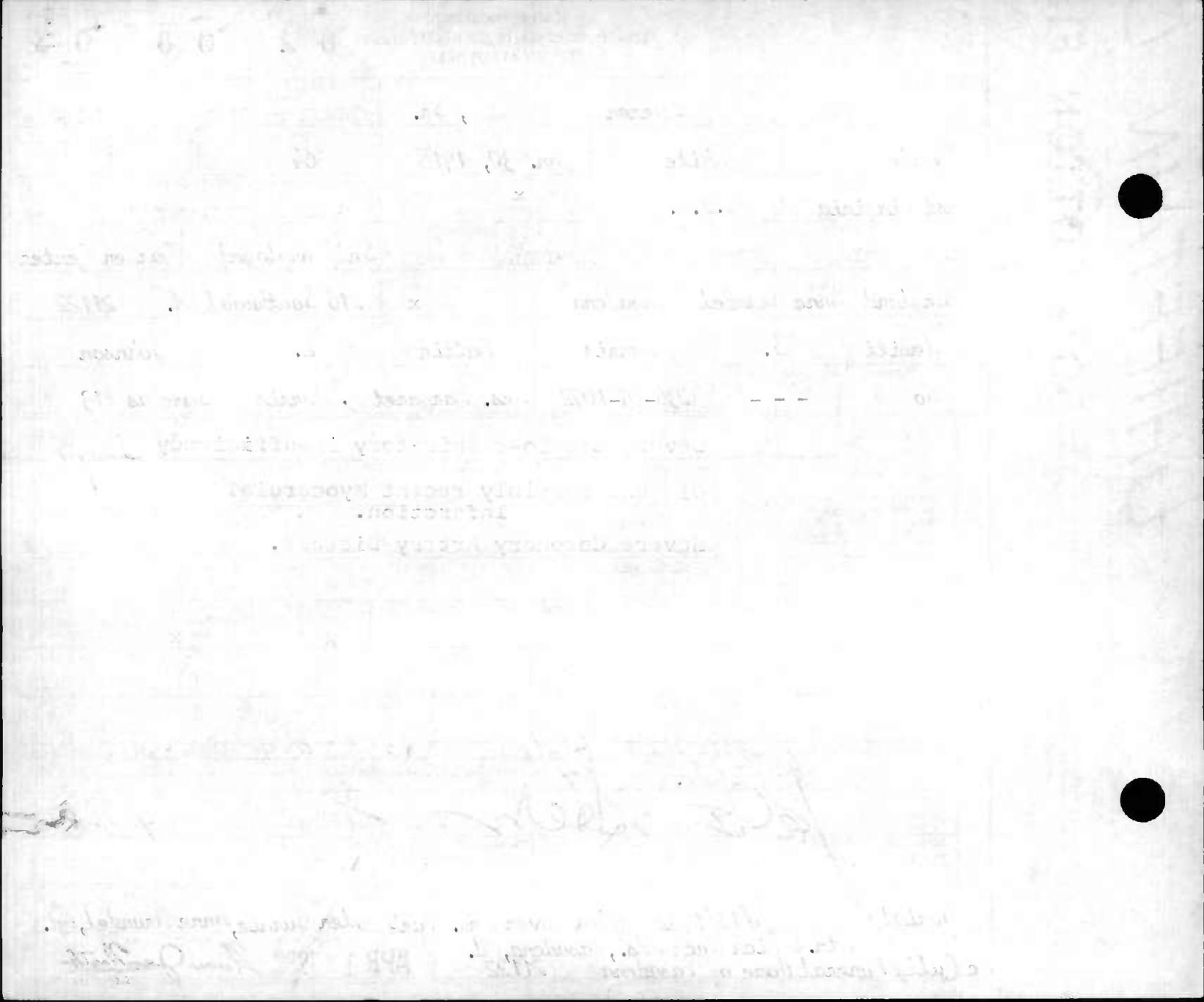
100-2222

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2	0 8	4 0	3				
										REG. NO.				EST			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR		
JAMES			Warren			HARRIS, Sr.			APRIL 9, 1982			6:38 P.M.					
3. SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male			White			Month Day Year Jan 30, 1918			64			MONTHS DAYS		HOURS MIN.			
7a BIRTHPLACE (COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
West Virginia			U.S.A.						ANNE ARUNDEL COUNTY								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY								
GLEN BURNIE			NORTH ARUNDEL HOSPITAL			Self employed			Garden Center								
13a STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS					
Maryland			Anne Arundel			Pasadena						216 Southwood Rd.			21122		
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			L.								
Hewitt			S.			Mattie			Johnson								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
No			236-05-1072			Mrs. Margaret E. Harris			Same as #13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH							
Severe Cardio-respiratory insufficiency 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) (b) Old and possibly recent Myocardial Infarction. (c) Severe Coronary Artery Disease.										days							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (i) (this hospital) attended the deceased from saw the deceased alive on 4/9/82 19 52 10 49 19 52, that (ii) (we) last saw the deceased dead on 4/9/82 19 52 10 49 19 52, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (iii) we did/did not view the body after death.																	
22b. SIGNATURE										22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			4/11/82					
JACK I. STERN, M.D.			300 HOSPITAL DR. GLEN BURNIE, MD. 21061														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNTY STATE					
Burial			4/12/1982			Glen Haven Mem. Park			Glen Burnie, Anne Arundel, Md.								
24. FUNERAL DIRECTOR NAME			Mc Cully Funeral Home of Pasadena			21122			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Mtn. & Tick Neck Rds., Pasadena, Md.									APR 13 1982			Anne Jan... Neath					

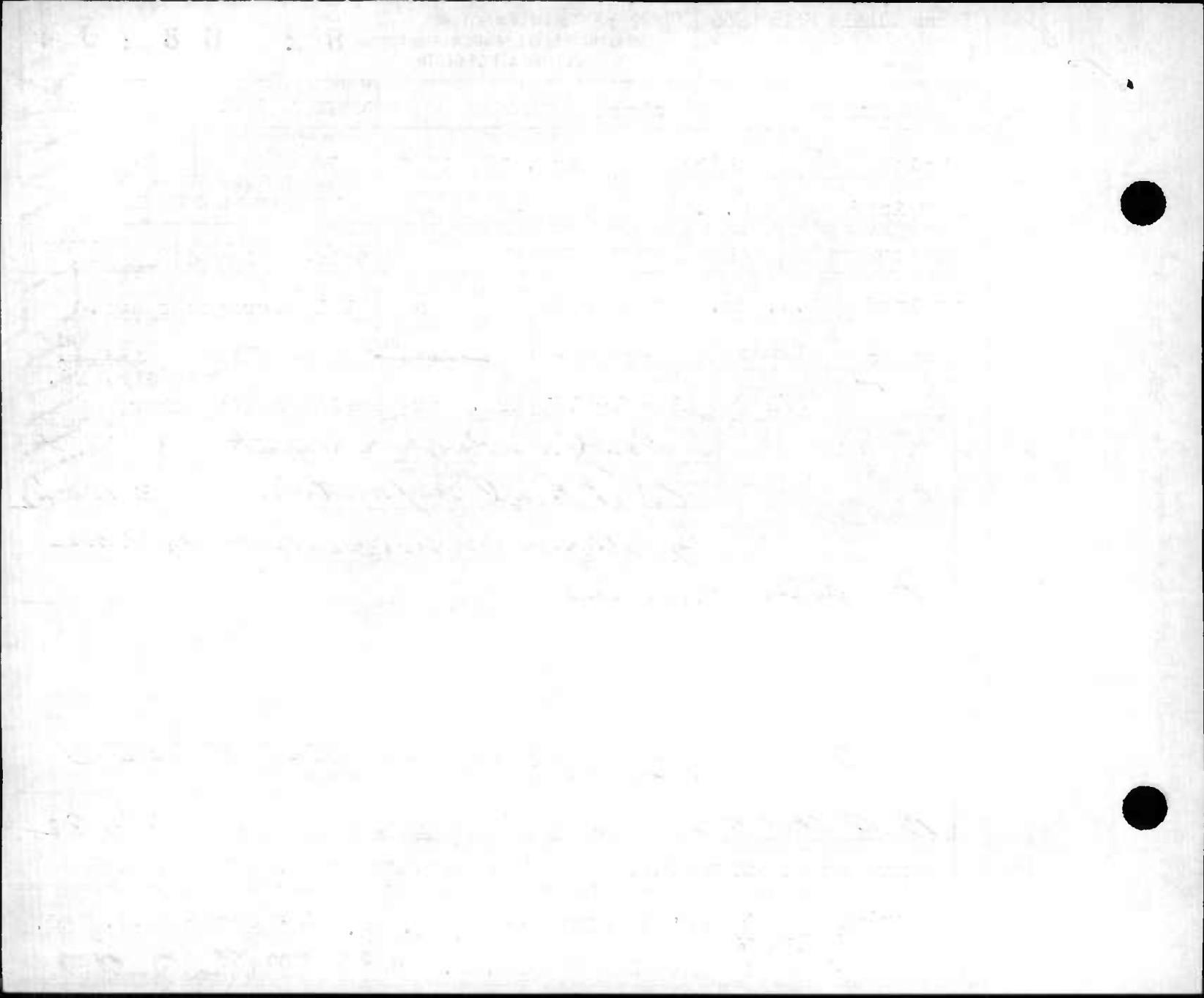


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or after traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAR			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. EST		
1. DECEASED NAME (TYPE OR PRINT)			FIRST GILBERT	MIDDLE Robert	LAST HARRYMAN	20 DATE OF DEATH APRIL 3, 1982			MONTH DAY YEAR	2b HOUR 6:15P M	
3. SEX Male			4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 15, 1905			6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY		
10. CITY OR TOWN OF DEATH GLEN BURNIE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT HOSPITAL, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-Employed			12b. KIND OF BUSINESS OR INDUSTRY Tavern Owner		
13a STATE Maryland			13b COUNTY A.A. Co.	13c CITY OR TOWN GlenBurnie	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS 1519 Furnace Ave.			
14. FATHER'S NAME FIRST Joshua			MIDDLE Thomas	LAST Harryman	15. MOTHER'S MAIDEN NAME FIRST Mary			MIDDLE Magdaline	LAST Feig Bailey		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A			17. INFORMANT Mrs. Mary Rawlings (Daughter)			ADDRESS Pasadena, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for item 18, and if PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a), 4029 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral infarction			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes					
			DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive cardiovascular disease						3 weeks		
PART 2 - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus											
19a DATE OF OPERATION 9/9			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that <input type="checkbox"/> (I) this hospital attended the deceased from 3/27 1982 , to 4/3 1982 , that <input type="checkbox"/> (we) last saw the deceased alive on 4/2 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE B. A. Alonso			DEGREE B.A. Alonso			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/3/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARDINO A. ALONSO, M.D.			22e. ADDRESS 1406 CRAIN HWY. GLEN BURNIE, MD. 21061								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7 APR '82			23c. NAME OF CEMETERY OR CREMATORIUM Glen Haven Mem. Pk.			23d. LOCATION CITY OR TOWN Glen Burnie A.A. Md.		
24. FUNERAL DIRECTOR NAME SINGLETON FUNERAL HOME, GLEN BURNIE, MD.			ADDRESS			25a. DATE REC'D. BY REGISTRAR APR 5 1982			25b. REGISTRAR'S SIGNATURE Home Day Miller		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8208405							
												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR							
<i>Katherine E. Hendricks</i>						July 3, 1982			4	10	82	5 ¹⁰ A.M.							
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR							
Female			White			July 3, 1911			10			MONTHS	DAYS	IF UNDER 24 HRS.					
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OR WORKING LIFE)			10b. KIND OF BUSINESS OR INDUSTRY				
MD			USA						Anne Arundel			Secretary Ret.			MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			12b. KIND OF BUSINESS OR INDUSTRY				
Annapolis			Anne Arundel General Hospital			MD			DA			19 Chester Avenue 21403			12c. ADDRESS				
13a. STATE MD			13b. COUNTY DA			13c. CITY OR TOWN Annapolis			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			12b. KIND OF BUSINESS OR INDUSTRY				
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 217-26-5667			17. INFORMANT Ray Hendricks			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Benjamin			Leitch			Martha			No			217-26-5667			Same as #13				
4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b),			(c)			DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
19b. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
21d. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f.														
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.															22c. DATE SIGNED <i>4/13/82</i>				
22b. SIGNATURE <i>H. Goldstein, M.D.</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>																			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL PRESS			23d. LOCATION CITY OR TOWN					
H. Goldstein, M.D.		205 Ridgely Ave; Annapolis, MD			Burial April 13, 1982			Glen Haven			Glen Burnie, Anne Arundel, MD			COUNTY STATE					
24. FUNERAL DIRECTOR NAME		25. DATE REC'D. BY REGISTRAR			26. REGISTRAR'S SIGNATURE			27. DATE REC'D. BY REGISTRAR			28. REGISTRAR'S SIGNATURE								
John M. Taylor & Sons, Annapolis, MD		APR 13 1982						APR 13 1982			Anne J. [Signature]								

of the first edition
published in 1824, and
the present edition is a copy of
the second edition published
in 1826. The title page of the
first edition is dated 1824
and the title page of the
second edition is dated 1826.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after issuance with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

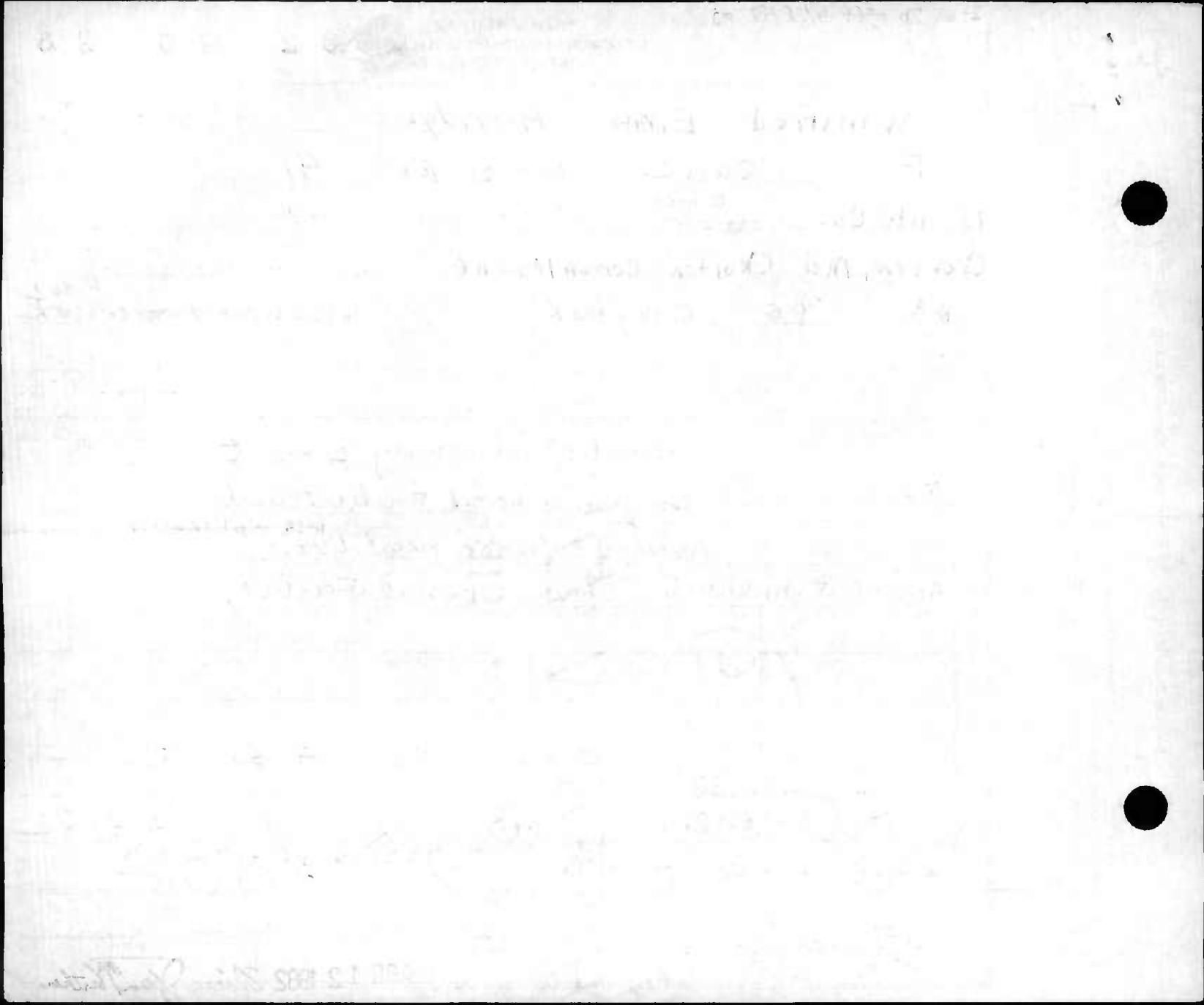
Item 7b g566 4/26/82 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 8 4 0 6

REG. NO.

1. FOR STATE REGISTRAR		20. DATE OF DEATH MONTH DAY YEAR 2b. HOUR Winifred Evans Herridge 4 6 82 1 PM									
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	20. DATE OF DEATH MONTH DAY YEAR 2b. HOUR						
3. SEX F		4 RACE CAUC	5. DATE OF BIRTH MONTH DAY YEAR Nov 21 1890	6 AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 91 YRS							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Toronto, Ca.		7b. CITIZEN OF WHAT COUNTRY? Canada		7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH xxxx Anne Arundel MD.				
10. CITY OR TOWN OF DEATH Crofton, md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Crofton Convalescent		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Service			12b. KIND OF BUSINESS OR INDUSTRY Secretary-Secretarial				
13a. STATE md		COUNTY PG	CITY OR TOWN College Park	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 600 Westchester Park #802				
14. FATHER'S NAME FIRST Alfred		MIDDLE	LAST Evans	15. MOTHER'S MAIDEN NAME Charlotte			16. ADDRESS 6100 Westchester Pk. Rainsford				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-24-9890		17. INFORMANT Charlotte Kraus Dr., College Park, md			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4140		19. DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart Failure and Poss. Septicemia.									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart disease									
20. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 3/27/1982 to 4/6/1982, that (I) (we) lost saw the deceased alive on 4/4/1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Rakesh Arora		22c. DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4/6/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAKESH ARORA, M.D.		22e. ADDRESS 3231 SUPERIOR LN BOWIE MD 20715									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/9/82		23c. NAME OF CEMETERY OR CREMATORIUM Rock Creek Cemetery			23d. LOCATION CITY OR TOWN Washington, D. C. COUNTY STATE				
24. FUNERAL DIRECTOR NAME Warner E. Pumphrey, Inc.		ADDRESS P.O. Box 7428 Sil. Spr., Md.		25a. DATE REC'D. BY REGISTRAR APR 12 1982			25b. REGISTRAR'S SIGNATURE James J. Weller				
VR A 15 (4)											

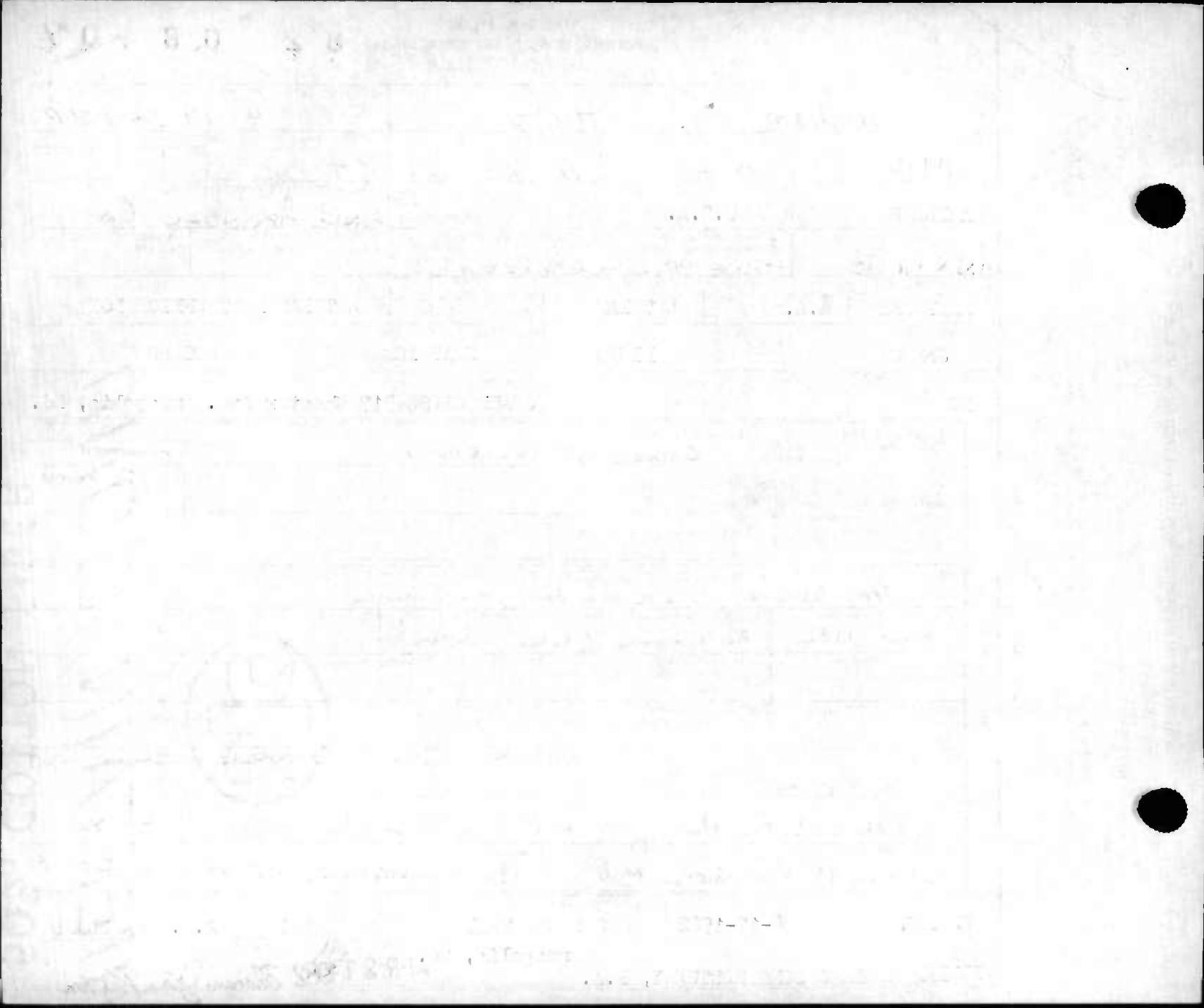


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8208407							
										REG. NO.							
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
			William Hicks						4 14 82			1:50 P.M.					
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
M ALE			N EGERO			11 05 27			54			YRS.					
7a. BIRTHPLACE COUNTRY MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL Co MD.								
10. CITY OR TOWN OF DEATH ANNAPOLIS			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE MARYLAND			13b. COUNTY A.A.			13c. CITY OR TOWN LOTHIAN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS LOTHIAN POST OFFICE BOX					
14. FATHER'S NAME FIRST JAMES			MIDDLE			LAST HICKS			15. MOTHER'S MAIDEN NAME BEATRICE			MIDDLE ROGERS			LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS								
NO						JOANN GROSS 317 Chester Ave. Annapolis, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER OF THE COLON										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MORE THAN 2 MONTHS							
1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) S/p Stroke, Seizure disorder, Hypertension																	
19a. DATE OF OPERATION March 1982			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Adenocarcinoma of Colon (Colostomy)			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from MARCH 20, 1982 , to APRIL 14, 1982 , that (II) (we) last saw the deceased alive on APRIL 14, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.																	
22b. SIGNATURE William B. Freedman										DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4.16.82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William B. Freedman M.D.										22e. ADDRESS 134 Owingsville Road, West River, MD 20728							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 4-17-1982			23c. NAME OF CEMETERY OR CREMATORIAL MOSES CEMETERY			23d. LOCATION CITY OR TOWN DRURY			COUNTY A.A.		STATE MARYLAND			
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.										25a. DATE REC'D. BY REGISTRAR APR 21 1982				25b. REGISTRAR'S SIGNATURE <i>James J. Hoban</i>			
DHMH - 16 50M 1/B1 (VRA 15, 4)																	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILE.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8 2 0 8 4 0 8	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR	
<i>MARGARET</i>			<i>M.</i>	<i>HIGGINS</i>		<input checked="" type="checkbox"/>	4		1982			M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR	
<i>F</i>	<i>W</i>	<i>9 8 09</i>	<i>72 yrs.</i>			<input checked="" type="checkbox"/>	4		13	82	P	M	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH						
<i>Pennsylvania</i>		<i>U.S.A.</i>			<input type="checkbox"/> NEVER MARRIED	<input type="checkbox"/> DIVORCED	<i>A. D. Co.</i>						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
<i>Glen Burnie</i>		<i>North Harford Hospital</i>			<i>Reg. Nurse-Ret.</i>								
13a. STATE MD.		13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Lot 40 Rol-Park Traillor Pk.					
14. FATHER'S NAME FIRST: <i>John</i>		MIDDLE: <i>Martin</i>		15. MOTHER'S MAIDEN NAME FIRST: <i>Anne</i>						LAST: <i>Grey</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. <i>166-32-7560</i>		17. INFORMANT		ADDRESS <i>Mrs. Margaret Millford 1302 Cory Drive</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest CVS</i> 4392 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Chronic</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			19c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21d. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>													
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>E. Linnhardt</i>		EXAMINER'S NAME (TYPE OR PRINT)		TITLE (SPECIFY) M.D. <i>Repetig</i>		MEDICAL EXAMINER		DATE SIGNED <i>4.13.82</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>Burial</i> 17 Apr. 82		23c. NAME OF CEMETERY OR CREMATORIUM <i>Calvary Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Pittsburgh Allegheny Penna.</i>		COUNTY STATE					
24. FUNERAL DIRECTOR NAME		ADDRESS <i>James S. Kirkley Glen Burnie, MD.</i>		25a. DATE REC'D. BY REGISTRAR <i>APR 16 1982</i>		25b. REGISTRAR'S SIGNATURE <i>James S. Kirkley</i>							

500

1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8208409
										REG. NO.
1 - FOR STATE REGISTRAR	FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)	IDA	THERESA	HIPPLER	APRIL 16, 1982				6:25 p		
3. SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
FEMALE	WHITE	NOV. 6, 1897			84 yrs					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10 CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MARYLAND MANOR CONV. CENTER			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER				12b. KIND OF BUSINESS OR INDUSTRY OWN HOME		
13a. STATE MARYLAND	13b. COUNTY A.A. CO.	13c. CITY OR TOWN GLEN BURNIE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 7900 BENESCH CIRCLE				
14 FATHER'S NAME FIRST GEORGE	MIDDLE	LAST GOODRICH	15 MOTHER'S MAIDEN NAME FIRST ANNA			MIDDLE	LAST DAHLE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. N/A	16c. IMMEDIATE CAUSE (a) pneumonia	17 INFORMANT (DAUGHTER) ADDRESS MRS. MARGARET L. BROWN, GLEN BURNIE			18 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) pneumonia										
DUE TO, OR AS A CONSEQUENCE OF (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8-14-, 19 81, to April 16, 19 82, that (I) (we) last saw the deceased alive on April 16, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										
22b. SIGNATURE Michael B. Pearlman, MD										
22c. DEGREE MD.										
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22d. DATE SIGNED 4-16-82										
22e. ADDRESS MD. MANOR CONV. CENTER										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 19 1982	23c. NAME OF CEMETERY OR CREMATORIUM LOUDON PK. CEMETERY	23d. LOCATION CITY OR TOWN BALTIMORE, MD.							
24 FUNERAL DIRECTOR NAME SINGLETON FUNERAL HOME	ADDRESS GLEN BURNIE MD.	25a. DATE REC'D. BY REGISTRAR APR 20 1982			25b. REGISTRAR'S SIGNATURE John J. H.					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached from the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death.

TO HOSPITAL OR ATTENDING PHYSICIAN. The retained by the hospital or attending physician

MEDICAL CERTIFICATION

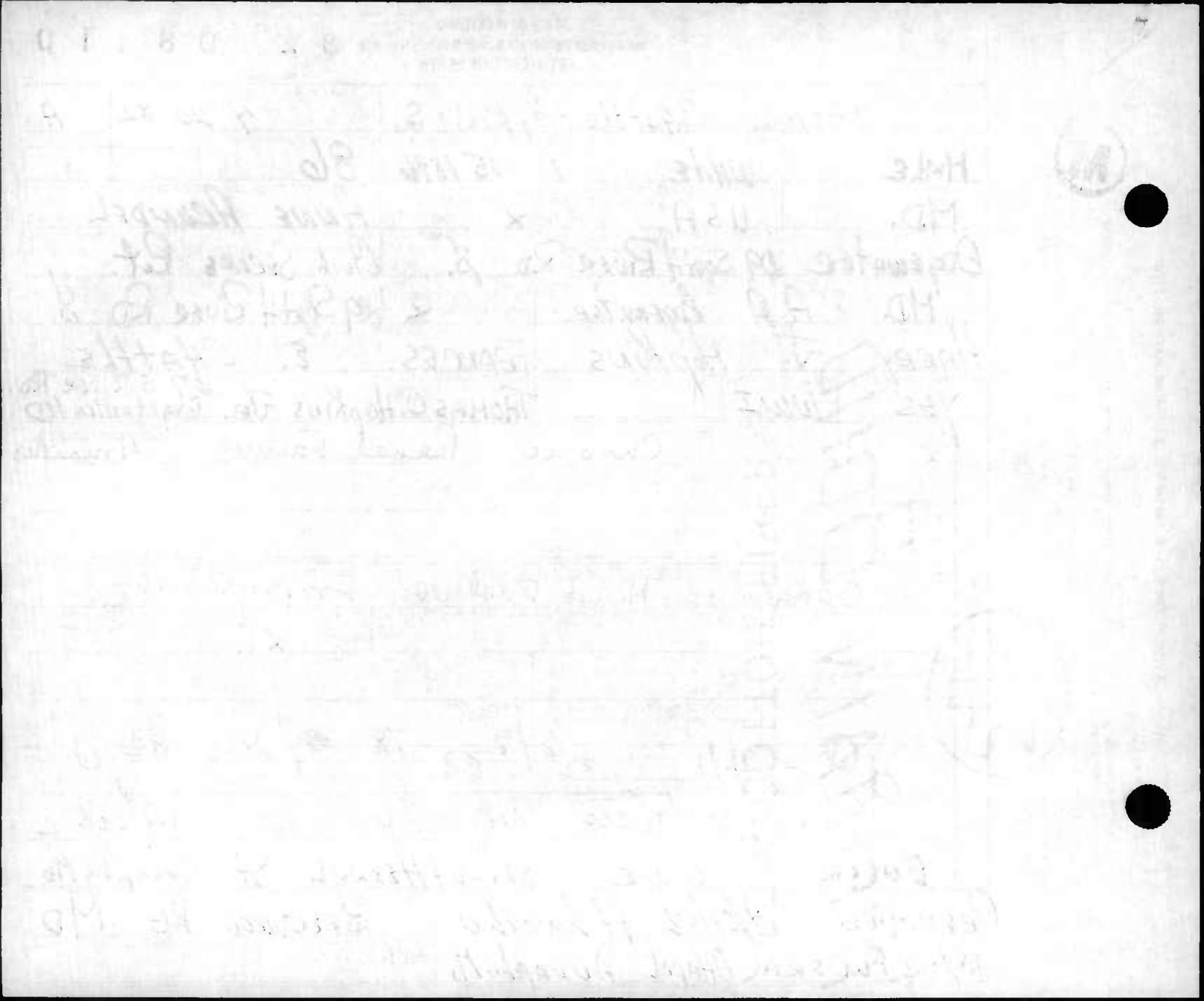
**1 - FOR
STATE
REGISTRAR**

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 8 4 1 0

REG. NO

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR		
Thomas Chatte Hopkins Sr.			4 20 82		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7 15 1896	6. AGE IN YEARS (LAST BIRTHDAY) 86	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS	IF UNDER 24 HRS MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE STATE (IF FOREIGN) MD.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALT. MORE CITY OR COUNTY OF DEATH HUNN HENDEL MD.		
10. CITY OR TOWN OF DEATH Odegwater			11. NAME OF HOSPITAL NURSING HOME OR OTHER INSTITUTION (DO NOT GIVE ADDRESS)		
12. USUAL RESIDENCE IF NURSING HOME OR OTHER INSTITUTION; GIVE RESIDENCE BEFORE ADMISSION MD A.A. Odegwater			13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cush Sevice Pet.		
14. FATHER'S NAME FIRST MIDDLE LAST Harry J. Hopkins			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES E. Chatte		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR & DATES) Yes WWI			16b. SOCIAL SECURITY NO. THOMAS C. Hopkins Jr. Engtwater Rd		
17. INFORMANT 5850			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Renal Failure DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 5850 DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Congestive Heart Failure, Smphy Serum					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	19c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERRING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 6/7 78 to 4/20 82			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 6/7 82 to 4/20 82 , and that in (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE Ensler W. Lee			DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4/20/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ensler Cope			22e. ADDRESS 131 Cathedral St. Annapolis Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 7/2/82	23c. NAME OF CEMETERY OR CREMATORIAL F. Hinrichs		23d. LOCATION CITY OR TOWN Brentwood PG MD.
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel Annapolis			25. DATE REC'D. BY REGISTRAR MD DEPARTMENT OF HEALTH SIGNATURE APR 22 1982		





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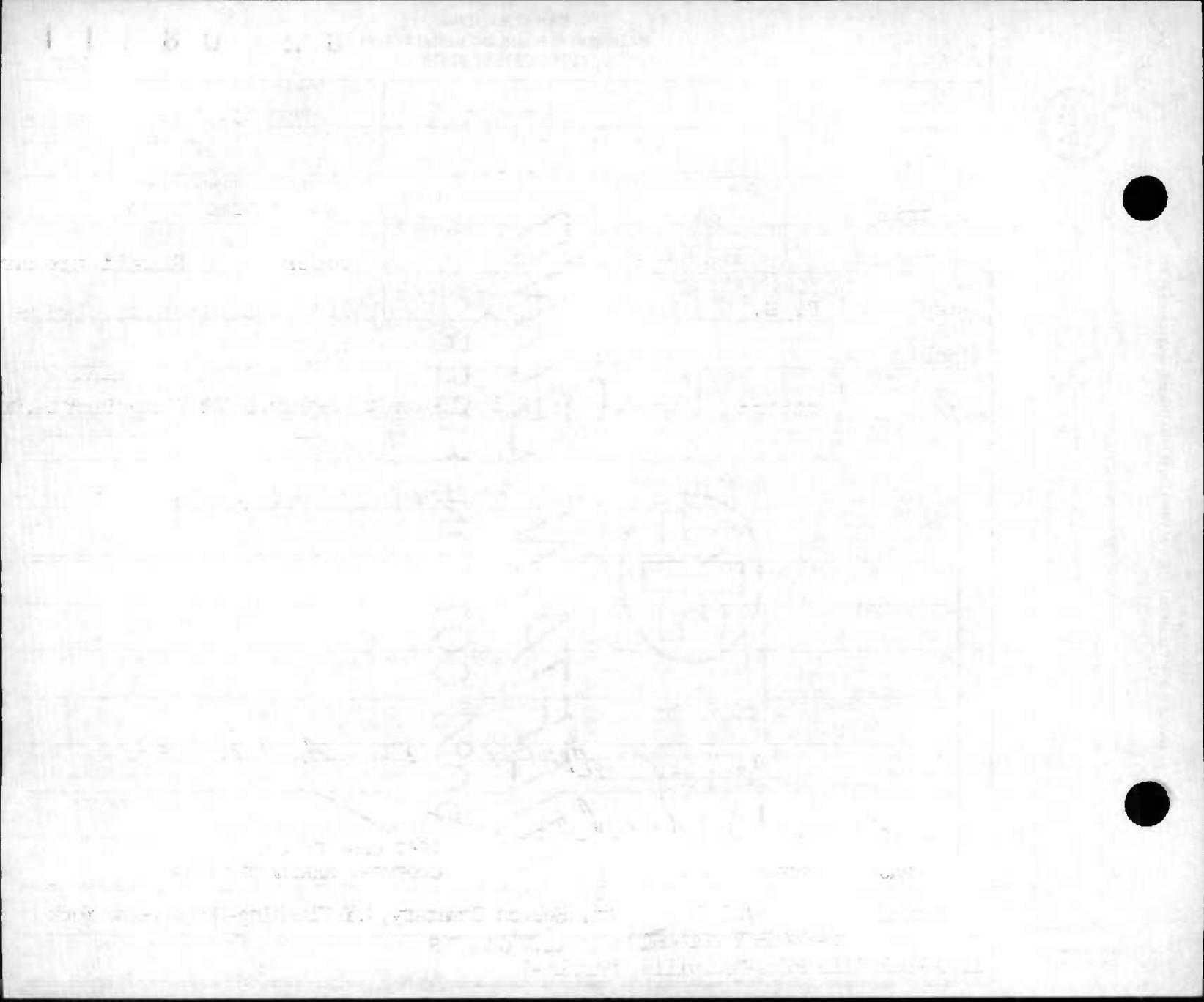
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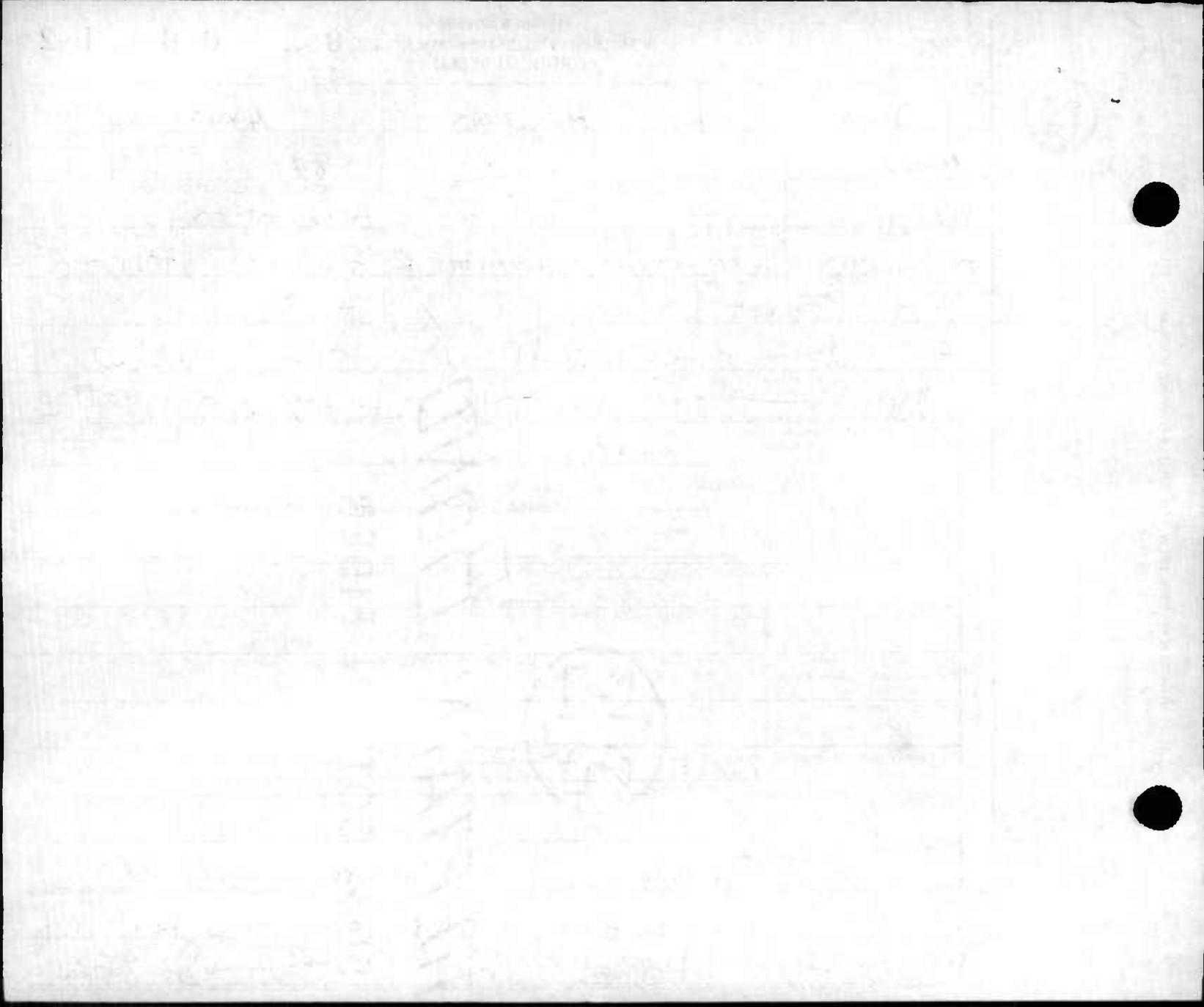


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

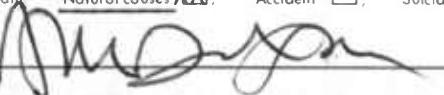
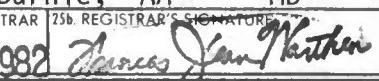
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

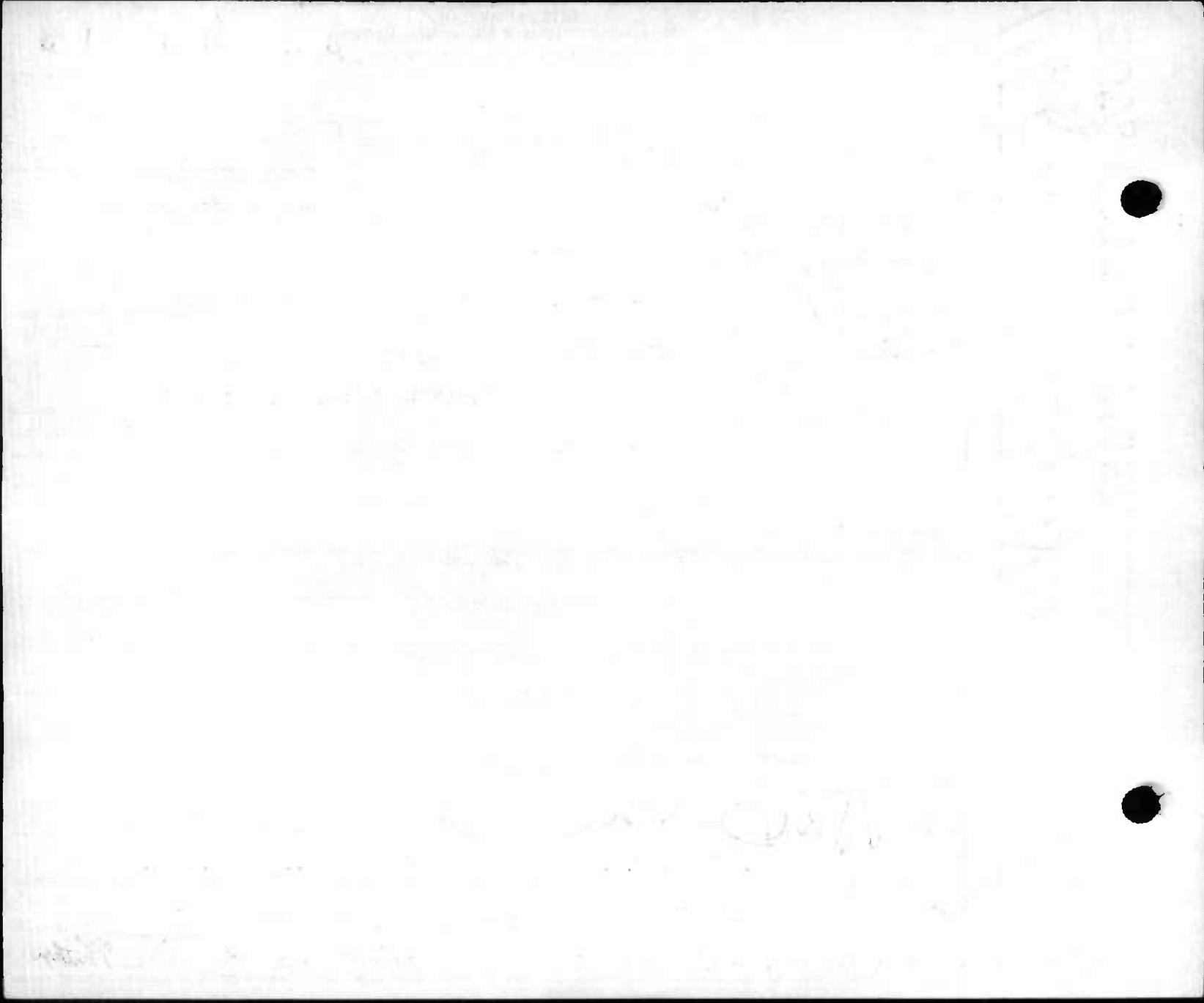
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner will be informed at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 4 1 2		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR 950PM
John T Hutchins						April 23 1982						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
MALE		white		1 30 95			87					
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD Anne Arundel		
Maryland		USA										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Annapolis		Anne Arundel General Hosp		farmer			tobacco					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) (STATE)		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS					
Md		Colbert Dings		NO			Rural					
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST				
Oyo F Clarence Hutchins				Mary Jane Webb								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS					
NO		018 363090		Kathryn Hutchins son			cott #13					
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) other acute cardiovascular disease												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) acute RLL pneumonia												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from April 23, 1982, to April 23, 1982, that (I) (we) last saw the deceased alive on April 23, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE B.T. Furrow		22c. DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
B.T. Furrow		77 West St Annapolis Md										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		CITY OR TOWN		COUNTY STATE		
Burial		4-27-82		Friendship Cemetery		Friendship		AA		Md		
24. FUNERAL DIRECTOR NAME		ADDRESS		25. WRITING BY MEDICAL EXAMINER OR REGISTRAR'S SIGNATURE								
Rausch Funeral Home		Mt. Dings		MAY 7 1982 Frances Jean Warthen								



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, REVERSE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR RECORDS. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2 0 8 4 1 3					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR					
AMY					JOHNS	<input checked="" type="checkbox"/>			4	27	1982	M					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR			
Female	White	Feb. 9, 1982			2	18	HOURS	<input checked="" type="checkbox"/>			4	27	1982	a M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED		NEVER MARRIED DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland		USA			<input type="checkbox"/>		<input type="checkbox"/>	Anne Arundel County									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Glen Burnie		North Arundel Hospital															
13a. STATE MD		13b. COUNTY AA		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1709 Kimber Road									
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST							
Franklin				Johns, Jr.		Sandra				Chapman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS										
No					Franklin Johns, Jr., Same as 13												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
7980 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?											
						<input checked="" type="checkbox"/>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>					
ACTUAL SIGNATURE 												TITLE (SPECIFY) M.D. Assistant			DATE SIGNED 4-27-82		
EXAMINER'S NAME (TYPE OR PRINT)			Ann M. Dixon, M.D.			ADDRESS			111 Penn St., Balto., Md. 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 30 April 82			23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Mem. Park			23d. LOCATION CITY OR TOWN Glen Burnie, AA			COUNTY		STATE			
Burial														MD			
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR APR 29 1982			25b. REGISTRAR'S SIGNATURE 								
James S. Kirkley, Glen Burnie, MD																	
BP																	
DHMH - 17 (VR A15 ME 55) 15M 2/80																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

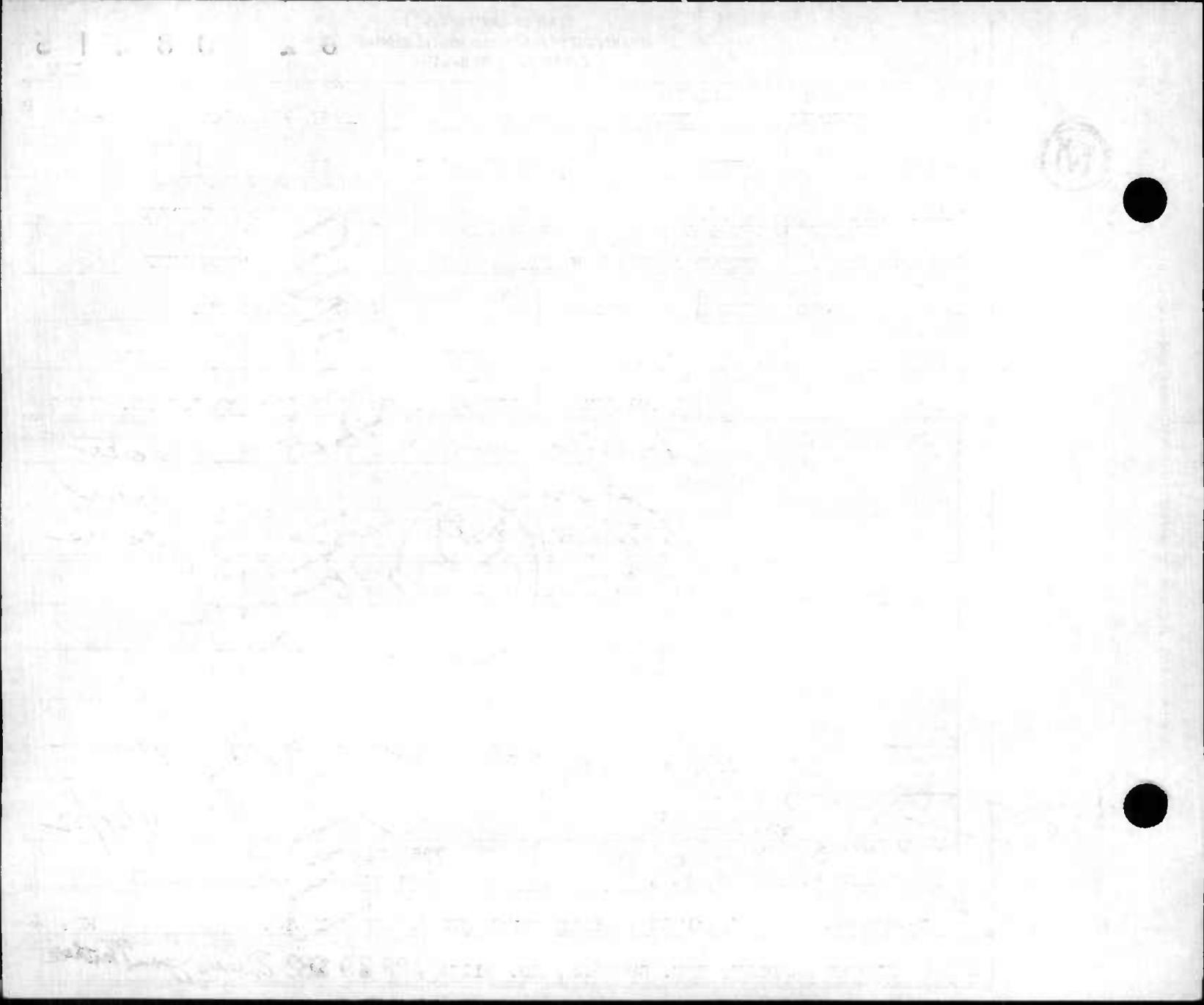
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. EST	
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR	
			ROBERT M. JONES						APRIL 14, 1982			12:06P	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			92 YRS			
Male		White		Sept. 20, 1889									
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.						
North Carolina		USA											
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-Employed			12b KIND OF BUSINESS OR INDUSTRY Auto. Upholster						
GLEN BURNIE		NORTH ARUNDEL HOSPITAL											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a STATE Maryland		13b COUNTY Anne Arundel		13c CITY OR TOWN Glen Burnie			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS Plaza Manor N.H. 7355 Furnace Branch Rd. 21061			
14 FATHER'S NAME Charles		MIDDLE Henry		LAST Jones			15 MOTHER'S MAIDEN NAME Sally			LAST Ann Keel			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. 212-18-7905		17. INFORMANT Robert M. Jones			ADDRESS Baltimore, Md. 21225 611 Pontiac Avenue,			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for item 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>old age, eva, etc</u>													
4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>saw the deceased alive on 4/15/52</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>H.A. Towhidian, M.D.</u>		22c. DEGREE MD.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 21122					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) HAMID A. TOWHIDIAN, M.D.		22f. ADDRESS 2334 MOUNTAIN RD., PASADENA, MARYLAND											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/21/1982		23c. NAME OF CEMETERY OR CREMATORIAL Maplewood Cemetery			23d. LOCATION CITY OR TOWN Kinston, Lenoir Co., N.C.			COUNTY STATE			
24. FUNERAL DIRECTOR NAME McCully Funeral Home		ADDRESS Md., 21225 237 E. Patapsco Ave.,		25a. DATE REC'D. BY REGISTRAR APR 10 1982			25b. REGISTRAR'S SIGNATURE <u>Frank J. Smith</u>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do not be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 4 1 5	EDT			
										REG. NO.				
1. FOR STATE REGISTRAR														
1. DECEASED NAME (TYPE OR PRINT)	ANNA DELMAR			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
	DEXXAR			JOYCE			APRIL 27, 1982						P 6:10	
3. SEX	4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS	
FEMALE	WHITE			MONTH DAY YEAR 8 - 31 - 1899			82			MONTHS	YEARS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
BALTO. MD.	U.S.A.						ANNE ARUNDEL COUNTY							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY
GLEN BURNIE	NORTH ARUNDEL HOSPITAL										HOMEMAKER			
13a. STATE MARYLAND	13b. COUNTY ANNE ARUNDEL	13c. CITY OR TOWN GLEN BURNIE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 6652 ROBERTS CT.								
14. FATHER'S NAME FIRST: JAMES MIDDLE: W. LAST: THOMAS	15. MOTHER'S MAIDEN NAME FIRST: ALICE MIDDLE: ANN LAST: READ													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 218.01.2338			17. INFORMANT GILBERT E. MITCHELL 109 CHARLES RD. 21090			ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))	5609 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Coronary artery collapse hour										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
5609	DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Intestinal obstruction beer beers													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic renal disease														
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHERE AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 4/27 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (or) (did not) view the body after death.	22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/28/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANASTACIO E. SUBONG, M.D.	22e. ADDRESS 7951 Oakwood Road Glen Burnie, Maryland 21061													
23a. BURIAL, CREMATION, REMOVAL CREMATION	23b. DATE 4/29/1982			23c. NAME OF CEMETERY OR CREMATORIAL GREEN MOUNT CREMATORIAL			23d. LOCATION CITY OR TOWN BALTO.			COUNTY	STATE			
24. FUNERAL DIRECTOR NAME WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222	25a. DATE REC'D. BY REGISTRAR APR 29 1982			25b. REGISTRAR'S SIGN Jan Weston										



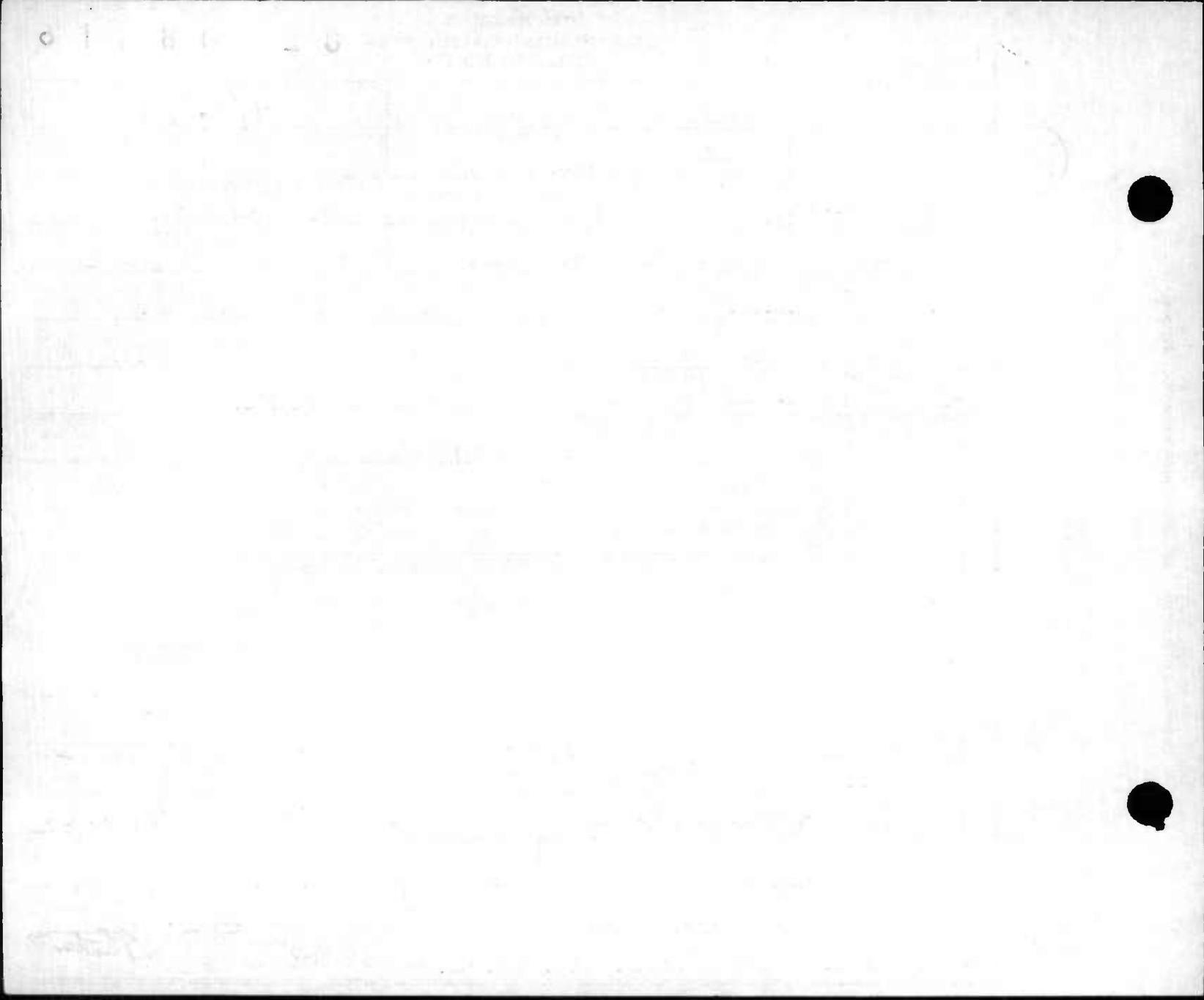
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 2 0 8 4 1 6	
					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST		2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Hal Latham Justice					4/26/82	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	
male	white	Feb. 13, 1914	68			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.			
North Carolina	USA					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.					12b. KIND OF BUSINESS OR INDUSTRY salesman food industry
Annapolis						
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 6076 Telegraph Rd.		
Md.	A.A.Co.	Severn				
14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME Orene Latham					
Charles Nelson Justice						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. -----	16c. INFORMANT Anna Justice same as 13e.	ADDRESS			
no	240-07-6229					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Lung cancer APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/82, 19_____, to 4/26/82, 19_____, that (I) (we) last saw the deceased alive on 4/26/82, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated 22b. SIGNATURE Stanley Watkins Jr.						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS 131 Cathedral Ann. Md.					22f. DATE SIGNED 4/27/82
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE Burial 4/28/82	23c. NAME OF CEMETERY OR CREMATORIAL Belair Memorial Gardens Cem. Belair Md.	23d. LOCATION CITY OR TOWN	COUNTY	STATE	
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home 12 Ridgely Ave. Ann. Md.	ADDRESS	25a. DATE REC'D. BY REGISTRAR AFR 29 1982	25b. SIGNATURE Jan Mather			
DHMH-16 30M 2/80 (VRA 15, 4)						

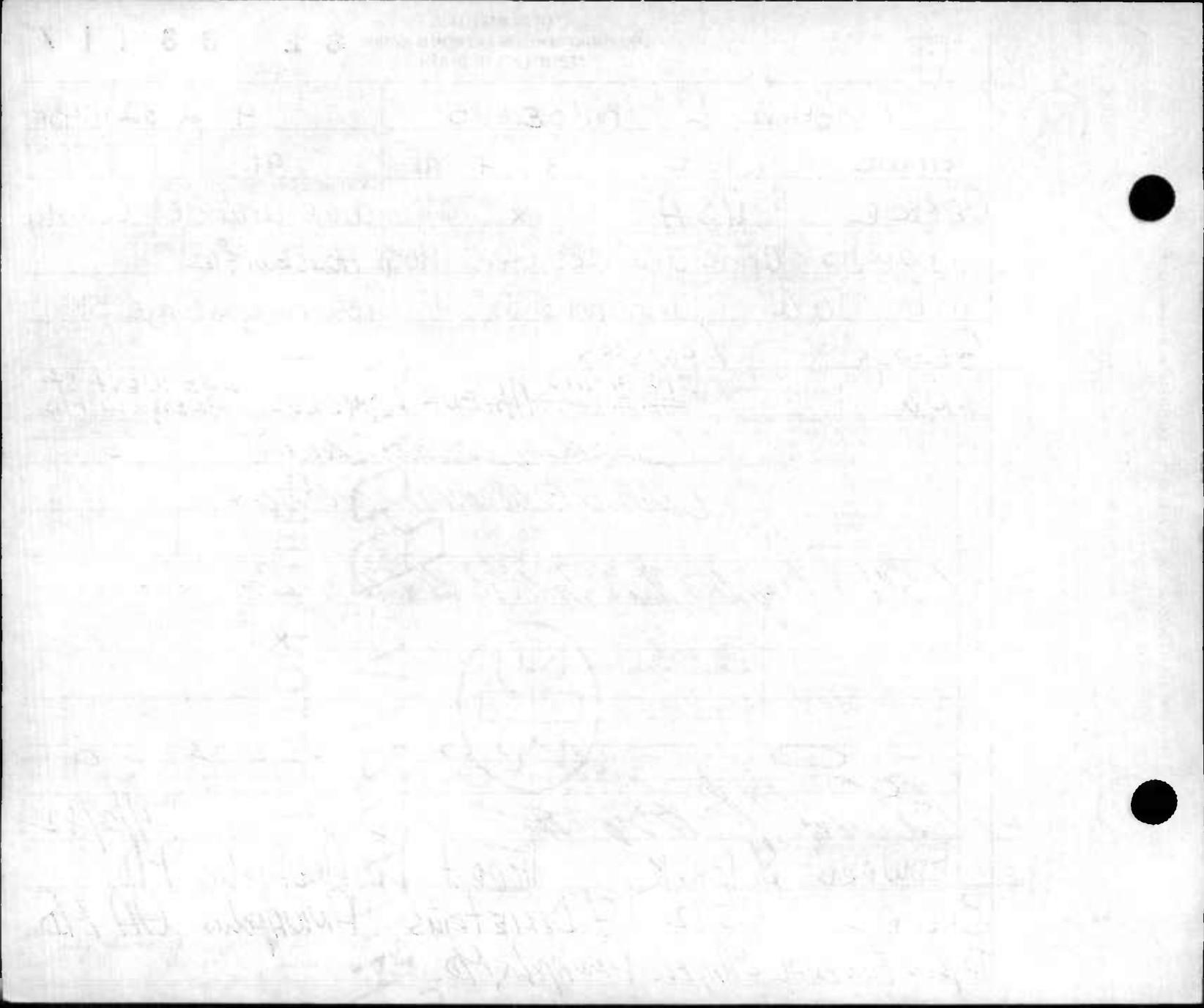


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be initialed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be attached to, or used as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8208417					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE		LAST			20. DATE OF DEATH	MONTH	DAY	YEAR	26 HOUR	
Christina L Katsoreles										4	2	82	11:45AM		
3. SEX		4. RACE			5. DATE OF BIRTH					6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
female		white			MONTH 3 DAY 4 YEAR 91					91	YRS.	MONTHS	DAYS	HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH					
Greece		USA								Anne Arundel County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Annapolis		Anne Arundel Gen. Hosp. Housewife													
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13a. STATE m.d.		13b. COUNTY laa		13c. CITY OR TOWN Annapolis		13e. STREET ADDRESS 139 King George St.									
14. FATHER'S NAME FIRST		MIDDLE		LAST											
George				LEWES											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NO 888-44-1007			16c. INFORMANT IRENE LAMBROS		ADDRESS 1108 WEST ST ANNAPOLIS MD.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0					
18. CAUSE OF DEATH (Enter only one cause per line) (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										Cerebral Hemorrhage					
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension, generalized															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d) Cystic Fibrosis, heart failure, Moderate Pneumonia															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3-3-82 to 4-2-82, that (I) (we) last saw the deceased alive on 4-3-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.										22b. DATE SIGNED 4/2/82					
22c. SIGNATURE EDWARD S. BARK										22d. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL BY		23b. DATE 4/5/82		23c. NAME OF CEMETERY OR CREMATORIUM St. Demetrios		23d. LOCATION ANNAPOLIS		23e. COUNTY MD		23f. DATE REC'D. BY REGISTRAR/CLERK/REGISTRAR'S SIGNATURE APR 5 1982					
24. FUNERAL DIRECTOR NAME TAYLOR FUNERAL CHAPEL ANNAPOLIS MD		ADDRESS													

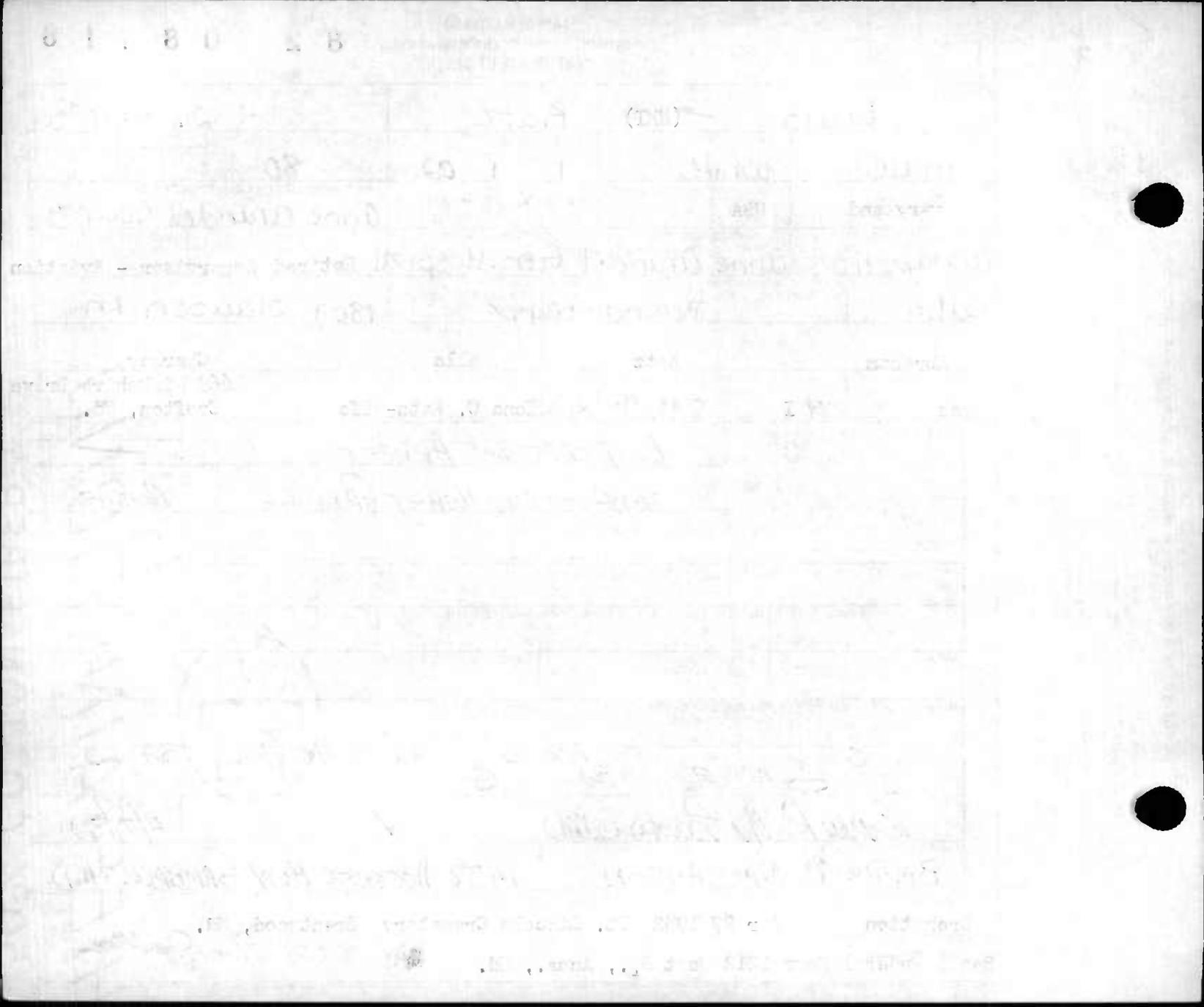


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8208418			
												REG. NO.			
1 - FOR STATE REGISTRAR			1a. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			Louis —(NMI) Katz						4 26 82			10:30 am			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
			male white			1 1 02			80 YRS						
7. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Anne Arundel County MD.			
Maryland			USA												
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Annapolis			Anne Arundel Gen. Hospital			Retired Supervisor - Aviation									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13. CITY OR TOWN			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
Calif.			Redondo Beach						1807 Slauson Ln.						
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
Abraham			Ella Cherney			548-09-7213			Iona C. Katz-Wife			1669 Wilkshire Drive Crofton, Md.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
yes			WW I			548-09-7213									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			19. DUE TO, OR AS A CONSEQUENCE OF (b)			20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
4280			Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			RESPIRATORY ARREST									
DUE TO, OR AS A CONSEQUENCE OF (b)			CONGESTIVE HEART FAILURE			Months.									
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) (this hospital) attended the deceased from APR. 16, 19 82, to APR. 26, 19 82, that (2) (we) last saw the deceased alive on APR. 26, 19 82, and that (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (we) did not view the body after death.															
22b. SIGNATURE BARRY R. NATHANSON MD			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4/27/82						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY R. NATHANSON			22e. ADDRESS 1438 Defense Hwy Gambrills MD.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Apr 27 1982			23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Crematory			23d. LOCATION CITY OR TOWN Brentwood, Md. COUNTY STATE						
24. FUNERAL DIRECTOR Beall Funeral Home 1212 West Street, Anna, Md.									25a. DATE REC'D. BY REGISTRAR APR 3 1982			25b. REGIS. NO.			



25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be forwarded for use as the burial-formal permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 8 4 1 9										
										REG. NO.										
1 - STATE REGISTRAR			FIRST			MIDDLE			LAST			2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR		
I. DECEASED NAME (TYPE OR PRINT)			William			Yager			Kitchin			April 5 1982			11	35	M	11 AM		
3. SEX			M			RACE			Cauc			5. DATE OF BIRTH			MONTH	DAY	YEAR	6 AGE (IN YEARS LAST BIRTHDAY)		
												87 8 05						IF UNDER 1 YEAR		
7a BIRTHPLACE COUNTRY			PA			7b CITIZEN OF WHAT COUNTRY?			USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			10 CITY OR TOWN OF DEATH		
															Annie Arundel			Annapolis		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			Anne Arundel General Hosp			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING WEEK)						12b. KIND OF BUSINESS OR INDUSTRY			Pharmacist Ret.					
																		P.O. Box 68		
13a STATE MD			13b COUNTY Calvert			14. FATHER'S NAME FIRST			LAST			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS White Hall Farm 20154			14c CITY OR TOWN Dunkirk		
						Frank Gunn Kitchin														
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			ND			16b SOCIAL SECURITY NO.			214-05-1085			17 INFORMANT Mrs. Richard L. Eisenman-Dunkirk, MD			ADDRESS P.O. Box 143					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days										
4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) Cerebro-Vascular Accident Cerebral Arterio-Sclerosis										
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arterio-Sclerosis										DUE TO, OR AS A CONSEQUENCE OF (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a). Severe Chronic Obstructive pulmonary disease.																				
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
												YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)			21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET					
																		CITY OR TOWN County State		
22a I certify that (I) (this hospital) attended the deceased from show the deceased alive on 4-5-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										22b DATE SIGNED 4-5-82										
22c SIGNATURE Peter F. Verkouw MD			22d PHYSICIAN'S NAME (TYPE OR PRINT) PETER F. VERKOUW			22e ADDRESS 1419 Forest Dr. Annapolis, Md.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f DATE SIGNED 21403								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE April 8 1982			23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge			23d. LOCATION City or Town Riversville			23e. BURIAL, CREMATION, REMOVAL CITY OR TOWN Balto								
24 FUNERAL DIRECTOR NAME John M. Taylor & Sons - Annapolis, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR APR 12 1982			25b. REGISTRAR'S SIGNATURE John M. Taylor											

8 1 1 6 0

the first time I have seen a
large number of them. They
are very small, about 1/2
inch long, and are found
in great numbers on the
leaves of the trees.

On the 2nd day we started
out at 6 A.M. and reached
the city of Guadalajara at
about 1 P.M. We stopped
at a hotel there and had
a good meal. In the evening
we took a walk around the
city and saw many interesting
things. We also visited
the cathedral and the
museum. The cathedral is
very large and beautiful.
The museum has a
collection of ancient
artifacts and artifacts
from the Aztec civilization.
We also saw some
of the local crafts and
handicrafts. The people
here are very friendly
and welcoming. We had
a good time in Guadalajara.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES.

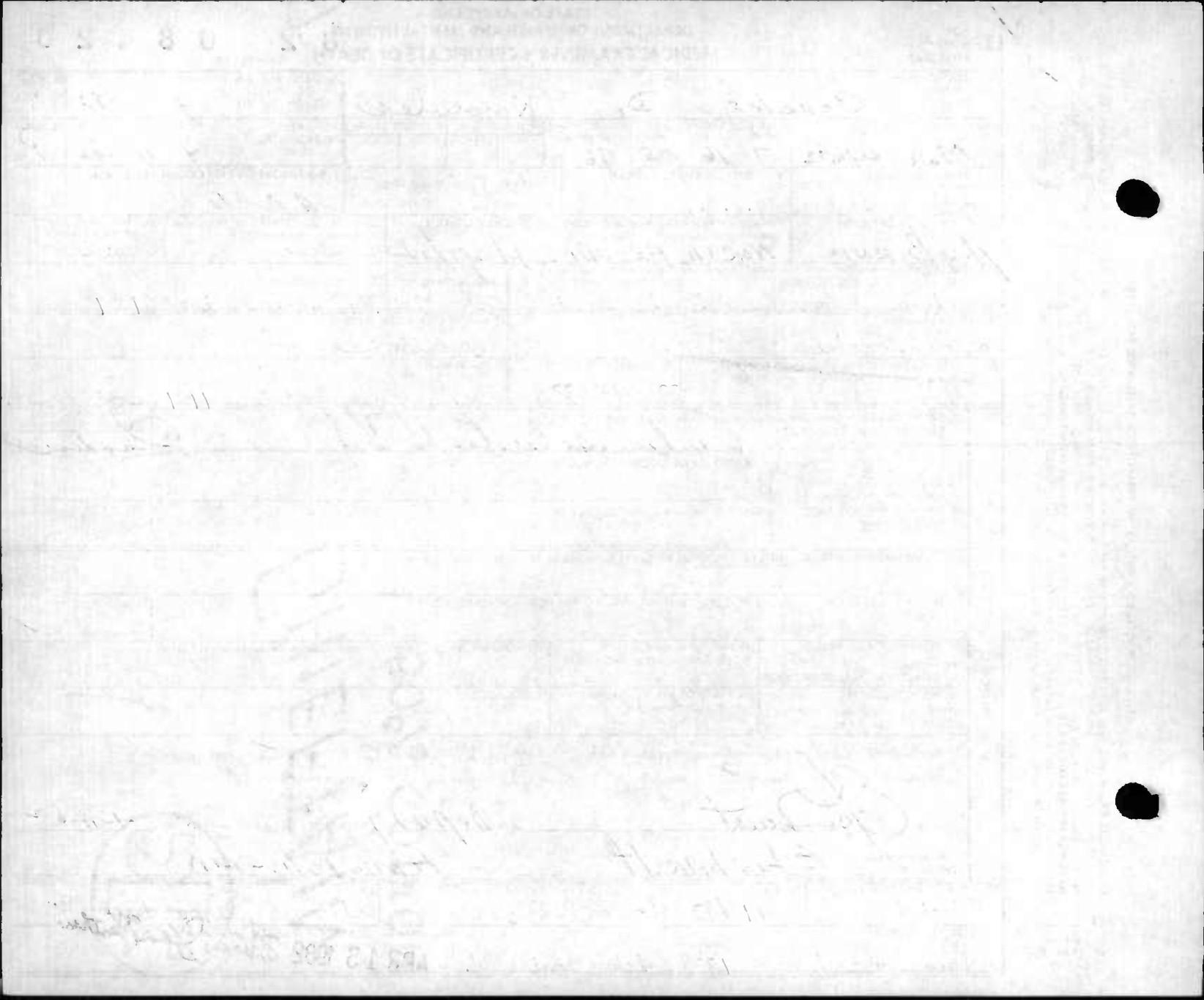
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8208420

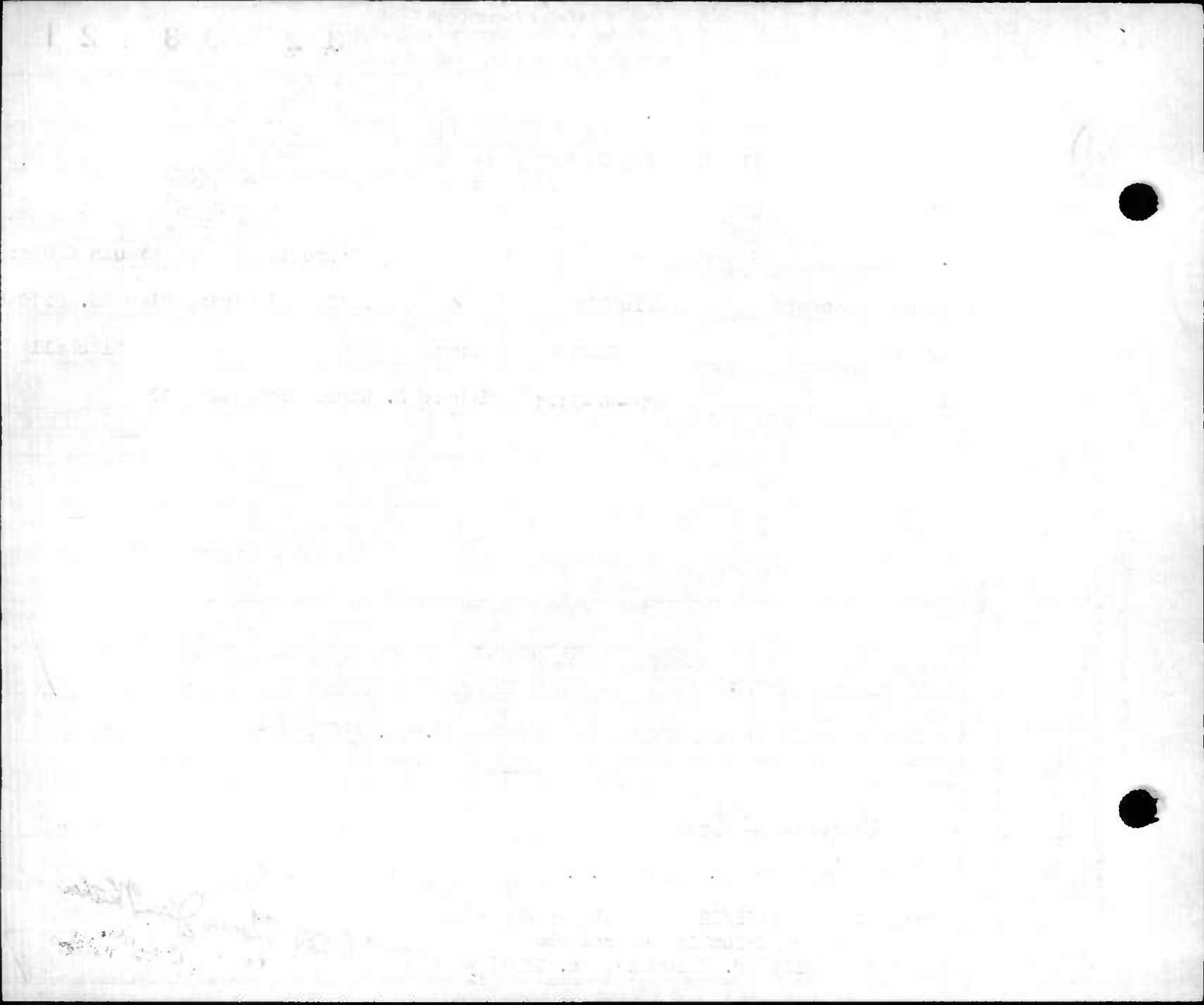
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	4	1982	?	M						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH	10. CITY OR TOWN OF DEATH									
North Carolina	U.S.A.				A.P.C.D.	Glen Burnie									
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS	14. FATHER'S NAME FIRST MIDDLE LAST								
Maryland	Anne Arundel	Glen Burnie				7677 Harlow Drive 21061	Watson D. Knowles								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) N/A			16b. SOCIAL SECURITY NO. 237-09-4933			17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					ADDRESS			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>John Bartlett</i>						
21d. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21g. LOCATION STREET CITY OR TOWN COUNTY STATE						
21h. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>															
22b. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>John Bartlett</i>										TIME (SPECIFY) M.D. Deputy 7 MEDICAL EXAMINER					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 4/14/82		23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery		23d. LOCATION CITY OR TOWN Baltimore City, Maryland STATE	
24. FUNERAL DIRECTOR NAME Ambrose Funeral Home										25a. DATE REC'D. BY REGISTRAR ADDRESS 1328 Sulphur Spring Rd.		25b. REGISTRATION NUMBER APR 13 1982			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2 0 8 4 2 1
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTI- MATED			MONTH	DAY	YEAR	2b. HOUR
Brenda			P.		Kopro	<input checked="" type="checkbox"/> 4			12	1982	M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR 3:29 P.M.
Female	Black	11 12 45	36			<input checked="" type="checkbox"/> 4			12	1982		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		USA						Anne Arundel County, MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Ft. Meade		Kimbrough Army Hospital			Counselor			Youth Center				
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Columbia	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 5313 Lightning View Rd. 21045				
14. FATHER'S NAME FIRST Ernest		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Susan				LAST Mitchell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-44-9141			17. INFORMANT Richard J. Kopro			ADDRESS Same as # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Multiple Injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (o) stating the underlying cause lost. 8120 (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR XXX MONTH DAY YEAR 2:38P.M. 4 12 1982			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver in auto/auto impact			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Road			21f. LOCATION STREET Dorsey Rd.-Rt. #176, Howard County, Maryland			CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Virginia L. Dolan</i>		TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 4-13-82				
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.		ADDRESS 111 Penn Street										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 4/15/82			23c. NAME OF CEMETERY OR CREMATORIAL Westview Memorial			23d. LOCATION Baltimore, Md.				
24. FUNERAL DIRECTOR NAME 5555 Twin Knolls Rd. Columbia, Md. 21045		25a. DATE RECEIVED APR 16 1982			25b. REGISTRAR'S SIGNATURE <i>Jean Martha</i>							
DHMH - 17 (VR A15 ME (5)) 15M 2/80												



p.3
Page 3 may be

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8208422			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Frank James Kovanda, Sr.						April 19, 1982									
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		Oct. 9, 1935			46 yrs			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Maryland		U.S.A.					Anne Arundel County, MD.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Glen Burnie		North Arundel Hospital										Manager		N.S.A.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS					
Maryland		A.A.		Gambrills			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2514 Silver Way					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST					
Joseph		Frank		Kovanda	Mary					Garrison					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT (Wife)			ADDRESS			Same as		13			
Yes		1955-1963		216/30/7760			Mrs. Edna Irene Kovanda								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4100 Conditions, if any, which gave rise to immediate cause (b), <i>myocardial Infarction</i>															
DUE TO, OR AS A CONSEQUENCE OF (b) <i>myocardial Infarction</i>															
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 1, 1982</i> , to <i>Apr. 19, 1982</i> , that (I) (we) last saw the deceased alive on <i>March 15, 1982</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (he) (she) (did not) view the body after death.															
22b. SIGNATURE <i>James S. Ahoder</i>		22c. DEGREE <i>MD</i>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>4/19/82</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>P. R. Hodder</i>		22e. ADDRESS <i>Crofton Md 21114</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Apr. 23, 82</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Gardens of Faith</i>			23d. LOCATION CITY OR TOWN		COUNTY		STATE				
24. FUNERAL DIRECTOR <i>D. H. Ahoder</i> NAME Singleton Funeral Home		ADDRESS <i>MD.</i>			Glen Burnie,			Baltimore Co., MD.							
25a. DATE REC'D. BY REGISTRAR <i>APR 20 1982</i>												25b. REGISTRAR'S SIGNATURE <i>James J. Smith</i>			

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 8 4 2 3

REG. NO.

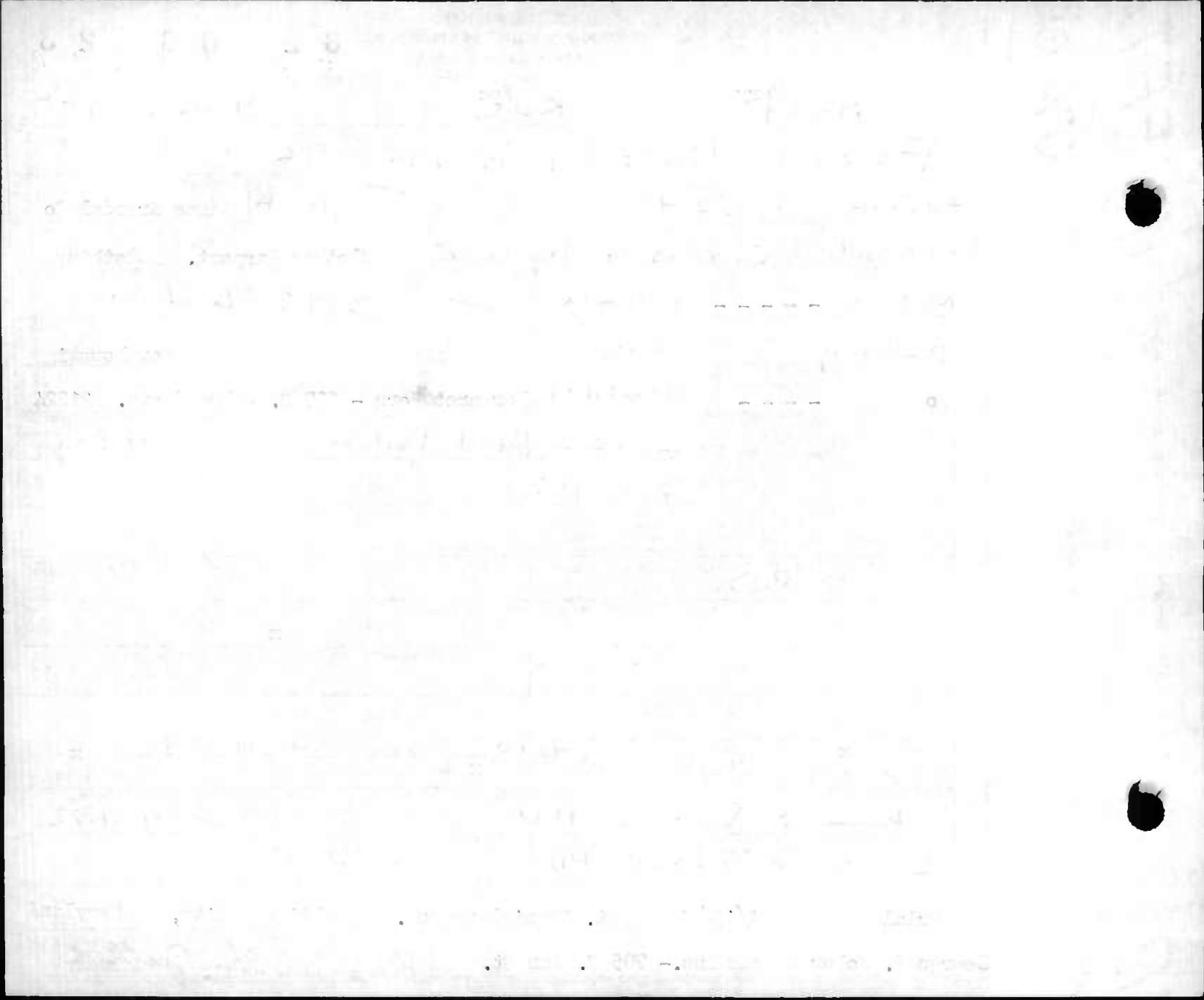
1 -
FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)	FIRST Mary	MIDDLE Kuc	LAST Kuc	2a DATE OF DEATH MONTH DAY YEAR 4-11-82	2b HOUR 7 A.M.
3. SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 1 15 1886	6 AGE (IN YEARS LAST BIRTHDAY) 96	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE COUNTRY Austria	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH (A.A.) Anne Arundel Co MD.		
10. CITY OR TOWN OF DEATH Crownsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Crownsville Hosp. Center	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clothes Inspect.	12b. KIND OF BUSINESS OR INDUSTRY Clothing		
13a STATE Md	13b COUNTY ---	13c CITY OR TOWN Baltimore	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 337 S. Ellwood Ave.	LAST
14. FATHER'S NAME FIRST Anthony	MIDDLE Kuc	15. MOTHER'S MAIDEN NAME FIRST Anna	LAST Nowakowski		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b SOCIAL SECURITY NO. 213-64-1109	17 INFORMANT Margaret Born	ADDRESS 337 S. Ellwood Ave. 21224		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. O.B.S.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 Days		
(b) DUE TO, OR AS A CONSEQUENCE OF A.S.H.D.					
(c) DUE TO, OR AS A CONSEQUENCE OF					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) O.B.S.					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4-10 , 19 82 , to 4-11 , 19 82 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4-11 , 19 82 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We did) <input type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE Luis R. Flores MD	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 4-11-82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Luis R. Flores MD	22e ADDRESS C. H. C.				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/15/82	23c. NAME OF CEMETERY OR CREMATORIUM St. Stanislaus Cem.	23d. LOCATION CITY OR TOWN Baltimore City	COUNTY	STATE Maryland
24 FUNERAL DIRECTOR NAME George A. Weber & Sons Inc.	ADDRESS 705 S. Ann St.	25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 12 1982			

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2
referred by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

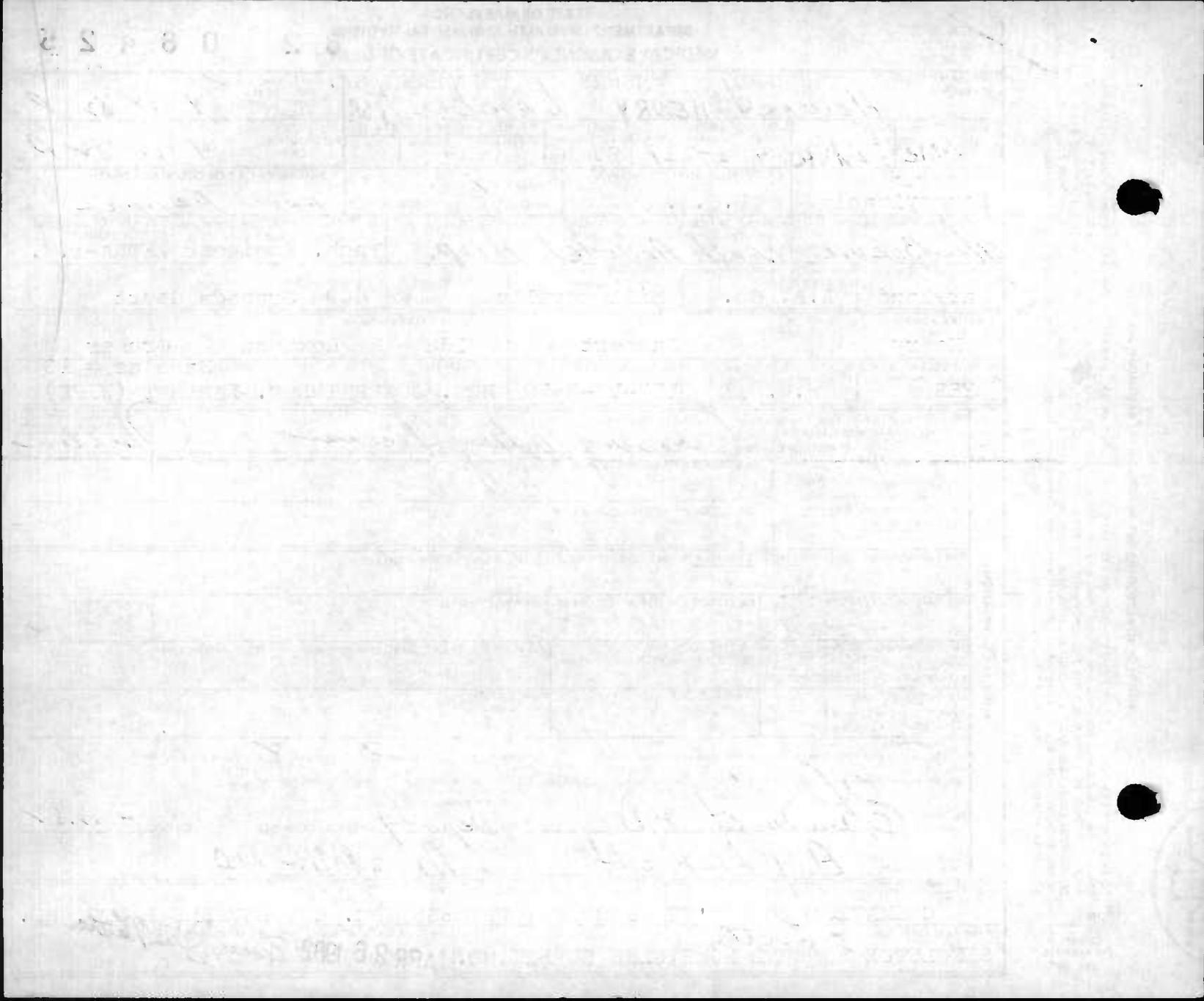
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 0 8 4 2 4 EST		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MARY	MIDDLE CATHERINE	LAST LANG	2a. DATE OF DEATH MONTH APRIL			DAY 6	YEAR 1982	2b. HOUR A 4:35			
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH Oct.			DAY 22	YEAR 1896	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 85	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	2b. HOUR HOURS 4:35
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY			MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.			13b. COUNTY A.A.			13c. CITY OR TOWN Riviera Bch			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 233 Carroll Rd. 21122		
14. FATHER'S NAME FIRST John			MIDDLE Fuka			15. MOTHER'S MAIDEN NAME FIRST Catherine			MIDDLE Cvach					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 217-03-8590			17. INFORMANT			ADDRESS					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction - 4148 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost { DUE TO, OR AS A CONSEQUENCE OF (b) Arterosclerotic cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from Jan 19 75 , to April 6 1982 , that (I) (we) last saw the deceased alive on Feb 17 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												22b. SIGNATURE Benito Martinez		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BENITO MARTINEZ, M. D.			22e. ADDRESS 2932A MOUNTAIN ROAD PASADENA, MARYLAND 21122			22f. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22g. DATE SIGNED 4-6-82					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/9/82			23c. NAME OF CEMETERY OR CREMATORIAL Holy Cross Cemetery			23d. LOCATION CITY OR TOWN Baltimore, Md.			COUNTY STATE		
24. FUNERAL DIRECTOR NAME Balto., Md. 21225						25a. DATE REC'D. BY REGISTRAR APR 8 1982			25b. REGISTRAR'S SIGNATURE George J. Gonce F.H. 4001 Ritchie Hwy.					

• 2 • 8 8 2 3

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE LINEAR DIRECTOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 6208425	
1. DECEASED NAME (TYPE OR PRINT)				FIRST <i>Howard</i>	MIDDLE <i>Henry</i>	LAST <i>Lambert, Sr.</i>	2a. DATE KNOWN OF ESTI- MATED	MONTH 4	DAY 22	YEAR 1882	2b. HOUR P		
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH 4	DAY 27	YEAR 21	6. AGE (IN YEARS (LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED		<input type="checkbox"/> DIVORCED		2c. DATE PRONOUNCED DEAD 4 22 1882					
10. CITY OR TOWN OF DEATH <i>Glen Bowie</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE ADDRESS) <i>North Arundel Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Tech. Engineer</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>TKTA-T.V.</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>A.A. Co.</i>		13c. CITY OR TOWN <i>Millersville</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS <i>449 Granada Court</i>					
14. FATHER'S NAME FIRST <i>Henry</i>				MIDDLE <i>Lambert</i>	LAST	15. MOTHER'S MAIDEN NAME FIRST <i>Ida</i>		MIDDLE <i>Roxanna</i>	LAST <i>Gruber</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>YES</i>				16b. SOCIAL SECURITY NO. <i>W.W. II 177-18-3679</i>				17. INFORMANT <i>MRS. JOSEPHINE V. LAMBERT (WIFE)</i>				ADDRESS <i>Same as # 13</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <i>4149 coronary artery disease</i>												IMMEDIATE CAUSE <i>4149</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <i>(b)</i> DUE TO, OR AS A CONSEQUENCE OF <i>DUE TO, OR AS A CONSEQUENCE OF</i> <i>(c)</i>	MAXIMUM INTERVAL BETWEEN ONSET AND DEATH <i>Clinton</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>E. G. Linhardt, MD</i>				TITLE (SPECIFY) <i>Deputy</i>				M.D. MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT) <i>A. G. Linhardt</i>				ADDRESS <i>Annapolis - MD</i>				DATE SIGNED <i>4. 22. 82</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>CREMATION</i>				23b. DATE <i>26 APR '82</i>	23c. NAME OF CEMETERY OR CREMATORIAL SECURITY PROCESS, INC. CATONSVILLE BALTIMORE MD.				23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME <i>J. Easter</i>				25a. DATE REC'D. BY REGISTRAR <i>APR 26 1982</i>				25b. REGISTRAR'S SIGNATURE <i>J. Easter</i>					
ADDRESS <i>SINGLETON FUNERAL HOME, GLEN BURNIE, MD.</i>													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 0 8 4 2 6										
												REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR										
Patricia Lillian Larson						April 18, 1982						A.M.										
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS										
Female		White		Nov. 29, 1908			73			MONTHS	DAYS	HOURS	MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.												
Illinois		U.S.A.					Anne Arundel															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY															
Glen Burnie		North Arundel Hospital		Home maker			Own Home															
13a. STATE Maryland												13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 208 Crain Court Circle		Apt 2A	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST											
Francis				Gesicki		Anastasia					Modrzejewska											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. N/A			17. INFORMANT (Daughter) ADDRESS Mrs. Patricia A. McLouski			205 Baylor Rd. 21061												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
4289 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																						
DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Failure																						
{ DUE TO, OR AS A CONSEQUENCE OF (c)																						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)																		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE											
22a. I certify that (I) (this hospital) attended the deceased from 6 1972, to April 19 82, that (I) (we) lost saw the deceased alive on 4-18-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 4/20/82										
22b. SIGNATURE <i>Dr. Paul Chang</i>		22d. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>																		
22e. PHYSICIAN'S NAME (IF APPLICABLE) Dr. Paul Chang		22f. ADDRESS 801 Crain Hwy. S.E. Glen Burnie, Md.																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 22, 1982		23c. NAME OF CEMETERY OR CREMATORIAL St. Adalbert Cem.			23d. LOCATION TOWN Niles, COUNTY Cook STATE Illinois															
24. FUNERAL DIRECTOR NAME R. George Mykles Singleton Funeral Home, Glen Burnie, Md.		25a. DATE REC'D. BY REGISTRAR APR 20 1982		25b. REGISTRAR'S SIGNATURE <i>Anne Jan Pfeiffer</i>																		
BP _____																						
DHMH - 16 50M 1/81 (VRA 15, 4)																						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8208427			
										REG. NO. EST			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
MARY E. LEUBA						APRIL 3, 1982						8:46 AM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		July 1, 1897			84			YRS.	MONTHS	DAYS	HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA								ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
GLEN BURNIE		NORTH ARUNDEL HOSPITAL								Homemaker			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			
Maryland		Baltimore		Randallstown						3805 Elmcroft Rd. 21133			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
Charles		Elsworth		Etchison	Estelle					Garver			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			Joppa, Md. ADDRESS 21085						
No		---		215-54-1668			Mr. Dallas H. Leuba 1711 Singer Rd.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 or PART 2)						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Apr. 3, 1982</i> to <i>Apr. 3, 1982</i> , that (I) (we) last saw the deceased alive on <i>Apr. 2, 1982</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we did not view the body after death.)													
22b. SIGNATURE <i>Charles J. Wu, M.D.</i>		22c. DEGREE								22d. DATE SIGNED <i>Apr. 3rd, 1982</i>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES J. WU, M.D.		ATTENDING MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/6/82		23c. NAME OF CEMETERY OR CREMATORIAL Prospect Cemetery			23d. LOCATION CITY OR TOWN Mt. Airy			COUNTY Frederick		STATE Md	
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc.		ADDRESS 8728 Liberty Rd. Randallstown, Md. 21133		25a. DATE REC'D. BY REGISTRAR APR 5 1982			25b. REGISTRAR'S SIGNATURE <i>Jones Jan Thresher</i>						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8208428			
										REG. NO.			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
		<i>Rose</i>				<i>LONG</i>		<i>April 21, 1982</i>					<i>7:00 AM</i>
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		WHITE		MONTH DAY YEAR <i>6-8-98</i>		83 YRS		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
N.Y.		USA				<i>A.A.-Co.</i>		SEVERNA PK		12 WISLER CT.		12b. KIND OF BUSINESS OR INDUSTRY <i>@ home</i>	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME MIDDLE LAST	
Md		AA		SEVERNA PK		YES <input type="checkbox"/>		12 WISLER CT.		Swinski		MARY SIKORSKI	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO								<i>Congestive Heart Failure</i>					
4292		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerotic Cardiovascular Disease</i>				DUE TO, OR AS A CONSEQUENCE OF (c) <i>Disease</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (This Hospital) attended the deceased from <i>Jan 15 Mar 1982</i> , to <i>21 April 1982</i> , that (I) (we) last saw the deceased alive on <i>15 Mar 1982</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Jon Blawie MD</i>		22c. DEGREE		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS <i>Annapolis, MD</i>		22f. DATE SIGNED <i>21 April</i>					
22g. PHYSICIAN'S NAME (IF APPLICABLE) <i>Jon Blawie</i>													
23a. BURIAL, CREMATION, REMOVAL SPECIES		23b. DATE <i>BURIAL 4/24/82</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Holy Cross Cem. CLARKSBURG W. VA.</i>		23d. LOCATION CITY OR TOWN		23e. DATE & "D. BY REGISTRAR IN REGISTRATION SIGNATURE <i>APR 23 1982</i>					
24. FUNERAL DIRECTOR NAME <i>Paul J. Banano Severna Park, Md 21146</i>													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 0 8 4 2 9													
												REG. NO.													
1 - FOR STATE REGISTRAR			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR							
1. DECEASED NAME (TYPE OR PRINT)			John Raymond			Longwell						4-24-82					1 PM	1 PM							
3. SEX			Male			4. RACE			Caucasian			5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)							
												Sept 16 1924			58			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			Pennsylvania			7b. CITIZEN OF WHAT COUNTRY?			USA			8			MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH						
10. CITY OR TOWN OF DEATH			Annapolis			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			Anne Arundel General Hosp			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			Biologist			12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE			Maryland			13b. COUNTY			Anne Arundel			13c. CITY OR TOWN			Annapolis			MD.							
14. FATHER'S NAME			Sidney R. Longwell			15. MOTHER'S MAIDEN NAME						13d. INSIDE CITY LIMITS?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS							
FIRST			MIDDLE			LAST												276 Hillsmere Drive							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			yes			16b. SOCIAL SECURITY NO.			WW II			17. INFORMANT			Fayetta A. Longwell			ADDRESS							
																					same as 13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						PART I. DEATH WAS CAUSED BY:						IMMEDIATE CAUSE (a)			Carcinoma of colon						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
												1539													
												Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) metastatic tumor										
												DUE TO, OR AS A CONSEQUENCE OF (c) + meso													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			abdomen			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE										
22a. I certify that (I) <input type="checkbox"/> attended the deceased from 3-27-1982 to 4-14-1982, that (I) <input type="checkbox"/> last saw the deceased alive on 4-24-1982, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did <input type="checkbox"/> not view the body after death.																									
22b. SIGNATURE			STEPHEN B. HILTABIDIE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			OCT 26 1982										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			Stephen B. Hiltabidie			22e. ADDRESS			801 Melvin Ave., Anna., Md.																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			Cremation			23b. DATE			Apr. 27 1982			23c. NAME OF CEMETERY OR CREMATORIAL			Lincoln Crematory			23d. LOCATION CITY OR TOWN			Brentwood, Maryland				
24. FUNERAL DIRECTOR NAME			Beall Funeral Home 1212 West St., Anna., Md.			25a. DATE REC'D. BY REGISTRAR			MAY 3 1982			25b. REGISTRAR'S SIGNATURE			James J. Gallagher										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 301 W. Preston Street, Baltimore, Maryland 21201.

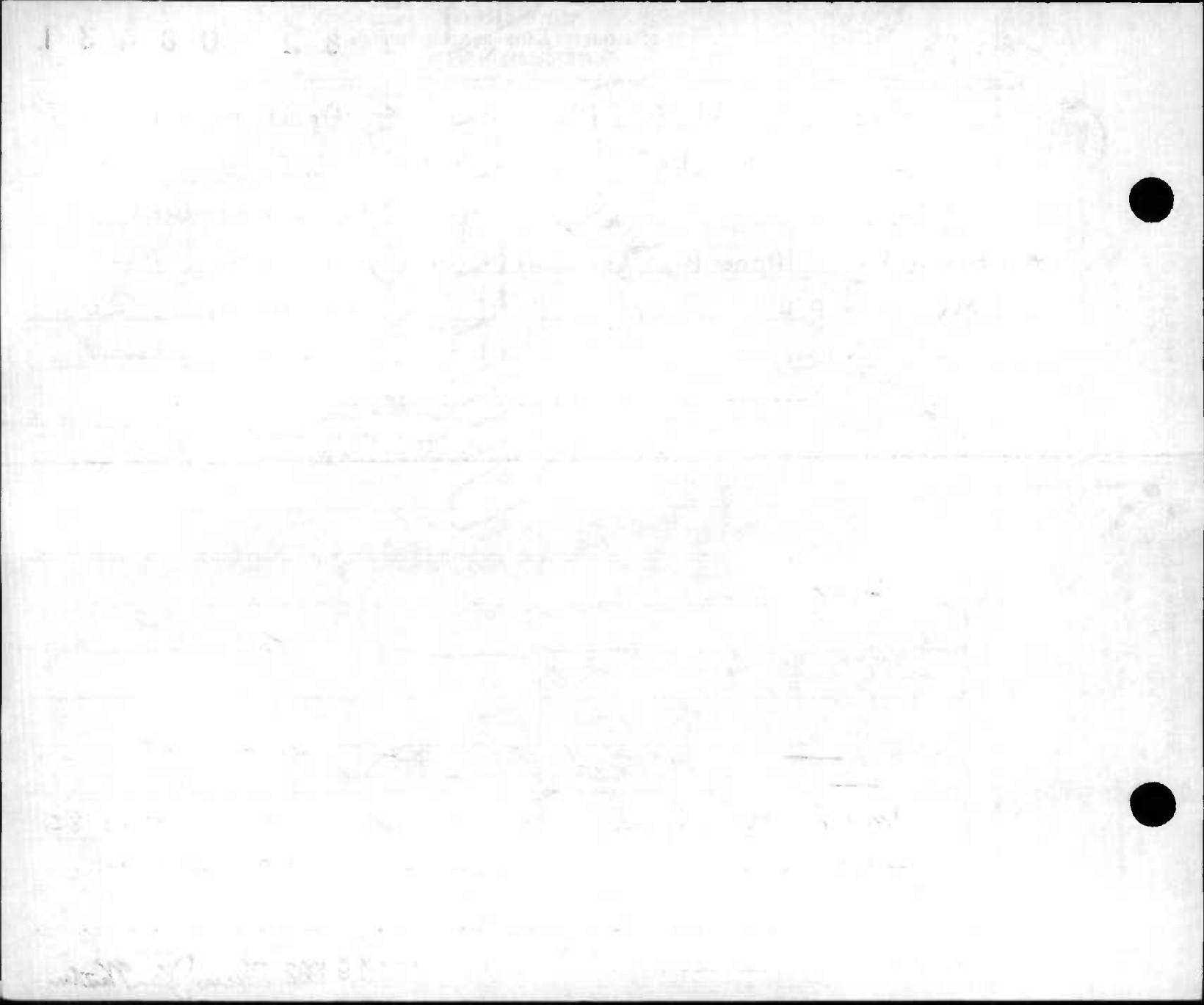
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8208430			
1. FOR STATE REGISTRAR			2. DECEASED NAME (TYPE OR PRINT)			LAST			2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR
OLIVER Glenn			MALONE, Sr.			April 15, 1982			P.M.						
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH April DAY 21 YEAR 1920			6. AGE (IN YEARS LAST BIRTHDAY) MONTHS 61 YRS. DAYS			IF UNDER 1 YEAR HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WV			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.						
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH CITY, GIVE STREET ADDRESS) 1062 Park Circle Drive			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manufacturer			12b. KIND OF BUSINESS OR INDUSTRY Tools						
13a. STATE MD			13b. COUNTY AA			13c. CITY OR TOWN Annapolis			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 1062 Park Circle Drive			
14. FATHER'S NAME FIRST Curtis			MIDDLE T.			LAST Malone			15. MOTHER'S MAIDEN NAME Wanda			LAST 21401 Hawkins			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW II			17. INFORMANT O. Glenn Malone, Jr.			ADDRESS Same as			#13			
18. CAUSE OF DEATH (Enter only one cause per line for item 18, and for item 18a, b, c, d, e, f, g, h, i, j, k, l, m, n, o, p, q, r, s, t, u, v, w, x, y, z.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Respiratory failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years 3352 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO, OR AS A CONSEQUENCE OF amyotrophic lat. Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) (late 9 elv's Disease)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from July 19, 1982, to April 16, 1982, that (I) (we) last saw the deceased alive on Jan 19, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Hawkins C. Wilkerson			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			DATE SIGNED 11/16/82						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D.C. Wilkerson			22e. ADDRESS 1563 St Margaret's, Annapolis, Maryland												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE April 20, 1982			23c. NAME OF CEMETERY OR CREMATORIAL MT. Zion			23d. LOCATION CITY OR TOWN Fairmont			COUNTY Marion	STATE WV		
24. FUNERAL DIRECTOR NAME John M. Taylor & Sons, Annapolis, MD			ADDRESS			25a. DATE REC'D. BY REGISTRAR APR 21 1982			25b. REGISTRAR'S SIGNATURE Frances Jean Fletcher						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of issue with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8208431	
REG. NO.													
1. FOR STATE REGISTRAR			DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 8:20 A.M.	
			George W. Marquess						April 14, 1982				
3. SEX Male			4 RACE White			5. DATE OF BIRTH Month Day Year Feb 22, 1917			6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE COUNTRY Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel			MD.	
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed			12b. KIND OF BUSINESS OR INDUSTRY Fuel				
13a. STATE Md.			13b. COUNTY A.A.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 810 Annapolis Rd.				
14. FATHER'S NAME Harry C. Marquess						15. MOTHER'S MAIDEN NAME Ella M. Marcellus							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-14-3701			17. INFORMANT Joan Marquess			ADDRESS 810 Annapolis Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs	
DUE TO, OR AS A CONSEQUENCE OF (b): DUE TO, OR AS A CONSEQUENCE OF (c):													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4 my home													
19a. DATE OF OPERATION 2/9			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 4-5, 1982, to 4-14, 1982, that (I) (we) last saw the deceased alive on 4-13, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.												22c. DATE SIGNED 4-15-82	
22b. SIGNATURE Hal R. Holstein			22d. PHYSICIAN'S NAME (TYPE OR PRINT) HOLSTEIN			22e. DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE April 17, 1982			23c. NAME OF CEMETERY OR CREMATORIAL BALDWIN CHURCH CEM.			23d. LOCATION CITY OR TOWN MILLERSVILLE				
24. FUNERAL DIRECTOR T.A. Hardesty			ADDRESS Annapolis, Maryland 21401						25a. DATE REC'D. BY REGISTRAR APR 19 1982			25b. REGISTRAR'S SIGNATURE D. Hardesty	
DHMH - 16 50M 1/81 (VRA 15, 4)													



Page 4 may be

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours
returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

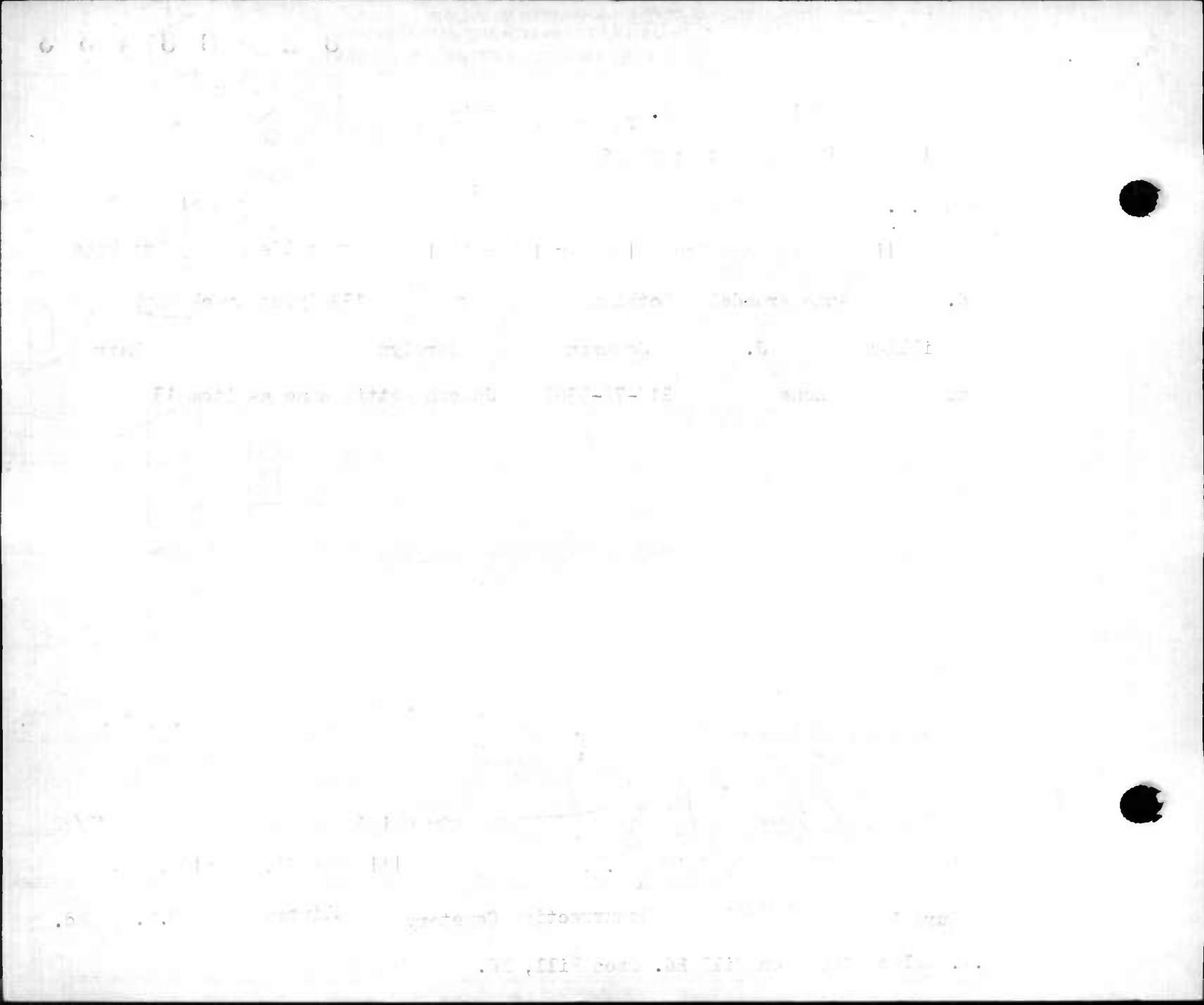
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8 2 0 8 4 3 2 REG. NO. EDT				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
ADELINE			HELEN		MATUSZEWSKI	APRIL 26, 1982						8:30 P M	
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		
Female			White		Nov. 4, 1942			39			IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland			U.S.A.					ANNE ARUNDEL COUNTY			MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
GLEN BURNIE			NORTH ARUNDEL HOSPITAL						Homemaker			Home	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
Maryland			Anne Arundel		Pasadena						7654 Bay St. 21122		
14. FATHER'S NAME			MIDDLE		LAST			15. MOTHER'S MAIDEN NAME					
Michael					Matuszewska, Sr			Margaret			Sadler		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)			16b. SOCIAL SECURITY NO.						17. INFORMANT			ADDRESS	
No			218-42-6793						Michael L. Matuszewska			Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) 4100			Cardio - Pulmonary Arrest									4 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			Due to, or as a consequence of (b) Acute myocardial infarct									1 hr	
			Due to, or as a consequence of (c) Severe coronary disease									years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
Diabetes													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
none													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 9/26/82, 1982, to 4/27/82, 1982, that (I) (we) last abre, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE									DEGREE			22c. DATE SIGNED	
Constantine J. Padussis, M.D.												4/27/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f. DATE SIGNED	
CONSTANTINE J. PADUSSIS, M.D.			500 Empire Towers 7310 Ritchie Highway, Glen Burnie, Md. 21061									4/27/82	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			STATE	
Burial			4/30/1982			Holy Cross Cemetery			Brooklyn Pk., Anne Arundel, Md.				
24. FUNERAL DIRECTOR NAME			ADDRESS						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE	
Mc Cully Funeral Home of Pasadena			21122						APR 29 1982			Anne Jan Martin	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3 RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH MATED			MONTH	DAY	YEAR	2b. HOUR	
Robin B. Mattia						<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4	6	1982	M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR	
Female	White	4 9 1955	26			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4	6	1982	M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH				
Wash D.C.			USA			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Anne Arundel County,				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Annapolis			Anne Arundel General Hospital			Housewife			at home				
13a. STATE Md.			13b. COUNTY Anne Arundel			13c. CITY OR TOWN Lothian			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 139 Lyons Creek Park	
14. FATHER'S NAME FIRST William			MIDDLE J.	LAST Johnson	15. MOTHER'S MAIDEN NAME FIRST Carolyn			MIDDLE	LAST Barr				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. none			17. INFORMANT Joseph Mattia same as item 13			ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9503 Diazepam intoxication DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 4/9/82			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Ingested diazepam			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home			21f. LOCATION Lot. 139 STREET Lyon's Trailer Pk. CITY OR TOWN Lothian COUNTY A.A. STATE Md.							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Thomas D. Smith</i> M.D. Deputy Chief MEDICAL EXAMINER												DATE SIGNED	4/7/82
EXAMINER'S NAME (TYPE OR PRINT)			Thomas D. Smith, M.D.			ADDRESS			III Penn St. Balto, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/9/82			23c. NAME OF CEMETERY OR CREMATORIUM Resurrection Cemetery			23d. LOCATION CITY OR TOWN Clinton COUNTY P.G. STATE Md.				
24. FUNERAL DIRECTOR NAME G.P. Kalas			ADDRESS 6160 Oxom Hill Ed. Oxon Hill, Md.			25a. DATE REC'D. BY REGISTRAR APR 12 1982			25b. REGISTRAR'S SIGNATURE <i>James Janis</i>				
DHMH - 17 (VR A15 ME (5)) 15M 2/80													

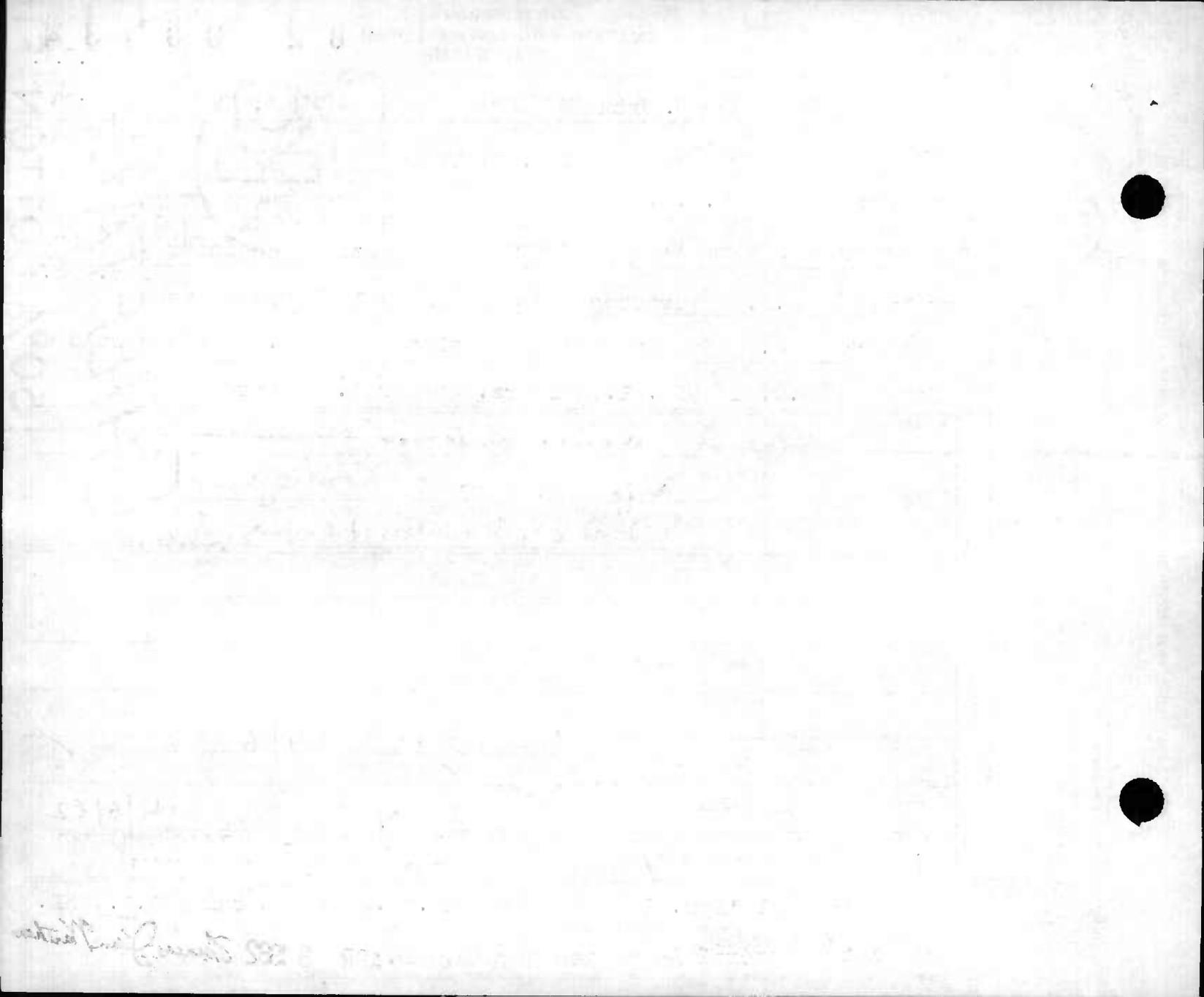


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 0 8 4 3 4 E.S.T.		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
LAWRENCE Farnsworth MAYNARD						APRIL 6, 1982						2:20 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White		Month Day Year Aug. 6, 1920			MONTHS DAYS			MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		
New York		U.S.A.										ANNE ARUNDEL COUNTY		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
GLEN BURNIE			NORTH ARUNDEL HOSPITAL									Safety Engineer		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Maryland			A.A.		Crofton					1527 Elwyn Avenue				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME								
			Robert	L.	Maynard	Helen								
						FIRST	MIDDLE	LAST						
						V.		Fitzgerald						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR ORDATES)			17. INFORMANT (Wife)			ADDRESS			12b. KIND OF BUSINESS OR INDUSTRY		
Yes			W.W. I			052.01.0665			Mrs. Evelyn B. Maynard			Con- tinental Ins. Co.		
Same as # 13														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													acute inferior myocardial infarction w/c Cardiogenic	
(b)														
(c)													shock, Cirrhosis + Esophageal varices.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
									YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4-1, 1982</u> to <u>4-6, 1982</u> , that (I) (we) last saw the deceased alive on <u>4-6, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>D. S. Sawhney</u> DEGREE														
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						22f. DATE SIGNED					
D. S. Sawhney			205 BALTIMORE-ANNAPOLIS BOULEVARD GLEN BURNIE, MARYLAND 21061						4/6/82					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION					
Burial			10 Apr. 82			Glen Haven Mem.Pk.			Glen Burnie, A.A., MD.					
24. FUNERAL DIRECTOR Singleton Funeral Home			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
												<u>Jean Hartman</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or after traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 2 0 8 4 3 5 EDT
1. DECEASED NAME (TYPE OR PRINT)		FIRST		LAST		2d. DATE OF DEATH		MONTH	DAY	YEAR	2d. HOUR	
FRANK		Anthony		MAZERSKI		APRIL 27, 1982					11:00M A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
male		white		Oct. 5, 1908		73		YEARS	MONTHS	DAYS	HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.				
Poland		USA										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INVESTMENT						
GLEN BURNIE		NORTH ARUNDEL HOSPITAL		Usher(ret)		Theater						
13a. STATE		13b. COUNTY		14. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1323 Furnace Road				
MD		AA		Linthicum								
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		LAST				
Victor				Mazerski		Mary		Anna Grubiel				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR RECORDS)		16c. INFORMANT		ADDRESS		same as 13				
Yes		WW II		218/01/9383		Mrs. Dorothy M. Howard (niece)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4148 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b). Recurrent Cardiac Arrest												
DUE TO, OR AS A CONSEQUENCE OF (c). old Myocardial Infarction												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 4/13/1982 to 4/27/1982 that (I) (we) last saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/27/82						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		205 BALTIMORE-ANNAPOLIS BLVD.								
DALJIT S. SAWHNEY, M.D.		GLEN BURNIE, MARYLAND 21061										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial		30 April 82		Holy Rosary		Baltimore				MD		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Singleton Funeral Home, Glen Burnie, MD				APR 29 1982		Frances Jean Kather						

YUNUS EZZINNA LIMA

DATA FOR DIVISION BY ROWS

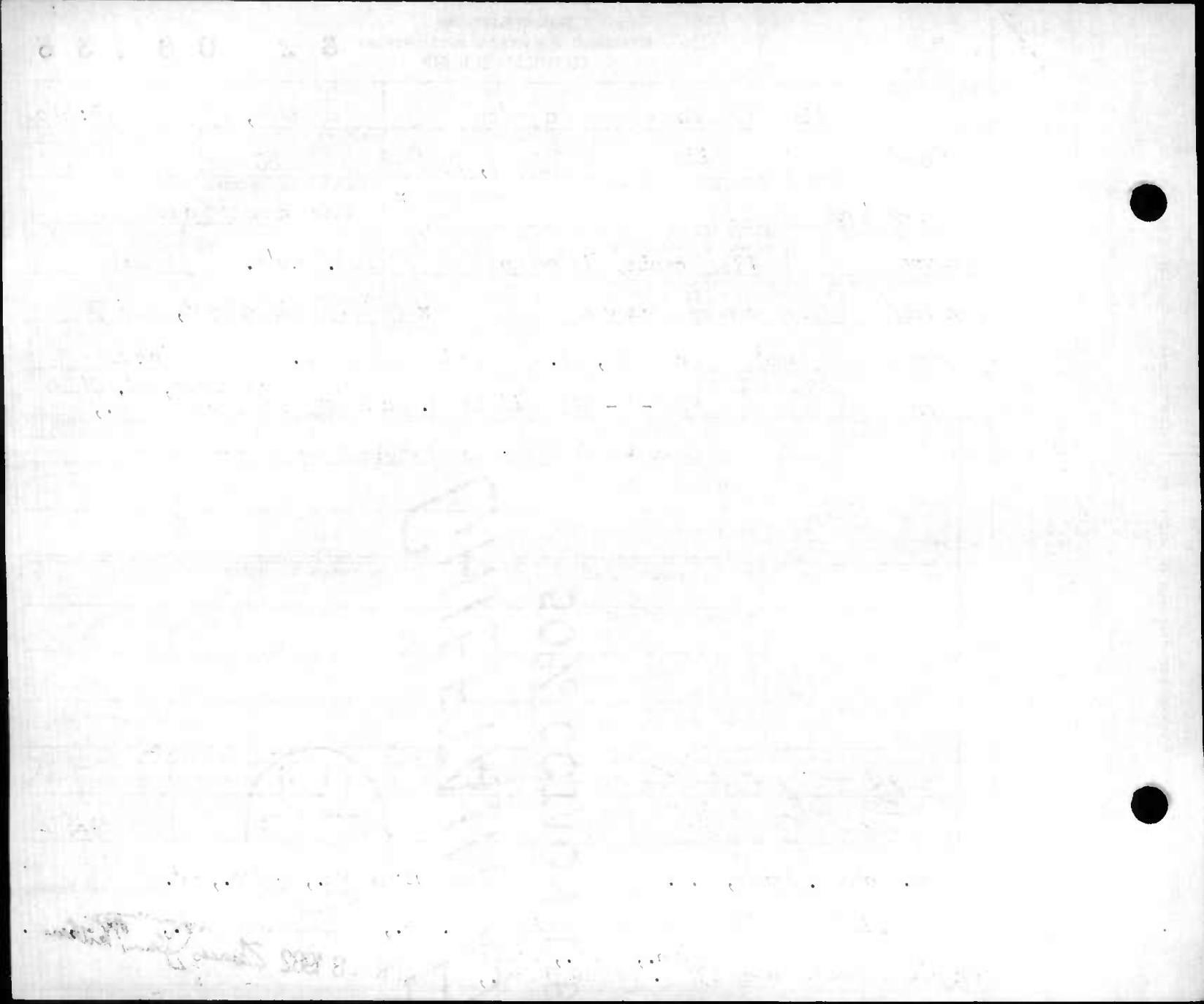
1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 8 4 3 6 | | | | |
|---|--|--|---|--------|---|--|---|-------------------------------|--|-----------------------------|--|--|-----|--|
| | | | | | | | | | | REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | | |
| Etta | | | May | | McCauley | April 4, 1982 | | | | | | 3:30 PM | | |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| Female | | | White | | MONTH DAY YEAR
July 1, 1921 | | 60 | | | MONTHS | YEARS | HOURS | MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | | |
| Maryland | | | USA | | | | Anne Arundel County | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Hanover | | | 1339 Weeping Willow Road | | | | | | Ret. Gov't. | | | SSA | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS | | | | |
| Maryland | | | Anne Arundel | | Hanover | | | | | 7154 Ridge Road, 21076 | | | | |
| 14. FATHER'S NAME | | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | | FIRST | MIDDLE | LAST | ADDRESS | | |
| Joseph | | | Edward | | McCauley, Sr. | | | | Goldie | K. | Rotan | Baltimore, Md. 21226 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | | | | 17. INFORMANT | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| no | | | 219-05-6913 | | | | | | William A. McCauley | | | 104 Sycamore Rd. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Ca of Lung & Melanoma</i> | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) _____ | | | | | | | | | | | | | | |
| { DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | YES <input type="checkbox"/> | NO <input type="checkbox"/> | YES <input type="checkbox"/> | NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/4/82</u> , 19 <u>82</u> , to <u>4/7/82</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>4/4/82</u> , 19 <u>82</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Dr. John C. Healy, M.D.</i> | | | 22c. DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22d. DATE SIGNED
<i>4/7/82</i> | | | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22f. ADDRESS | | | | | | | | | | | |
| Dr. John C. Healy, M.D. | | | 1311 Francis Ave., Balto., Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIUM | | | 23d. LOCATION
CITY OR TOWN | | 23e. COUNTY STATE | | | | |
| Burial | | | 4/8/1982 | | Meadowridge Mem. Pk., | | | Washington Blv. | | Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME | | | ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR / REGISTRAR | | | 25b. DATE REC'D. BY REGISTRAR / REGISTRAR | | |
| McCully Funeral Home | | | Balto. Md., 21225
237 E. Patapsco Ave., | | | | | | APR 8 1982 James | | | James | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | 8 2 0 8 4 3 7
E.S.T. | | | | | | |
|--|--|--|---|--------|------|---|--|-------------------|---|--|----------|---|-------|--------------------------------|--|--|--|--|
| 1 - STATE REGISTRAR | | | | | | | | | | | REG. NO. | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | | | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | | | | |
| ANN BOYSEN McMULLIN | | | | | | | | APRIL 20, 1982 | | | | | | 8:10PM _M | | | | |
| 3. SEX
Female | | | 4. RACE
White | | | 5. DATE OF BIRTH
July 24, 1921 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 | | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
New Jersey | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY | | | MD. | | | | | | |
| 10 CITY OR TOWN OF DEATH
GLEN BURNIE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Home Maker | | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | Apt. T2 | | | | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Arundel | | | 13c. CITY OR TOWN
Glen Burnie | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS
8047 Winding Wood Road | | | | | | |
| 14. FATHER'S NAME
John | | | 15. MOTHER'S MAIDEN NAME
Boysen | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
None | | | 17. INFORMANT
(son) 7903 Kreger Dr. Apt. 205
Paul McMullin Adelphi, Md. 20783 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

1749 IMMEDIATE CAUSE (a) <i>respiratory arrest</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b)
(c)
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>metastatic breast carcinoma</i> | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET | | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>autumn</i> , 19 <i>81</i> , to <i>april 5</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>april 5</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Douglas Orr.</i> | | | 22c. DEGREE
MD | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22d. DATE SIGNED
4-22-82 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME
(TYPE OR PRINT)
Dr. Douglas Orr | | | 22e. ADDRESS
Oncology Center John's Hopkins Hosp.
Baltimore, Md. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
April 24, 1982 | | | 23c. NAME OF CEMETERY OR CREMATORIAL
Security Process | | | 23d. LOCATION
CITY OR TOWN
Catonsville | | | COUNTY
BALTIMORE | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
B. H. Hopkins | | | ADDRESS
Singleton Funeral Home, Glen Burnie, Md | | | 25a. DATE REC'D. BY REGISTRAR
APR 22 1982 | | | 25b. REGISTRATION NUMBER
<i>James J. Smith</i> | | | | | | | | | |
| BP _____ | | | | | | | | | | | | | | | | | | |
| DHMH - 16 50M 1/81
(VRA 15, 4) | | | | | | | | | | | | | | | | | | |

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123

БИБ

СЕРГЕЙ АЛЕКСАНДРОВИЧ

ИЛЬИН

СЕРГЕЙ

ИЛЬИН

УЧИЛ. БОРИС ВИЧ.

МАСТЕР-ШИКАНДАР

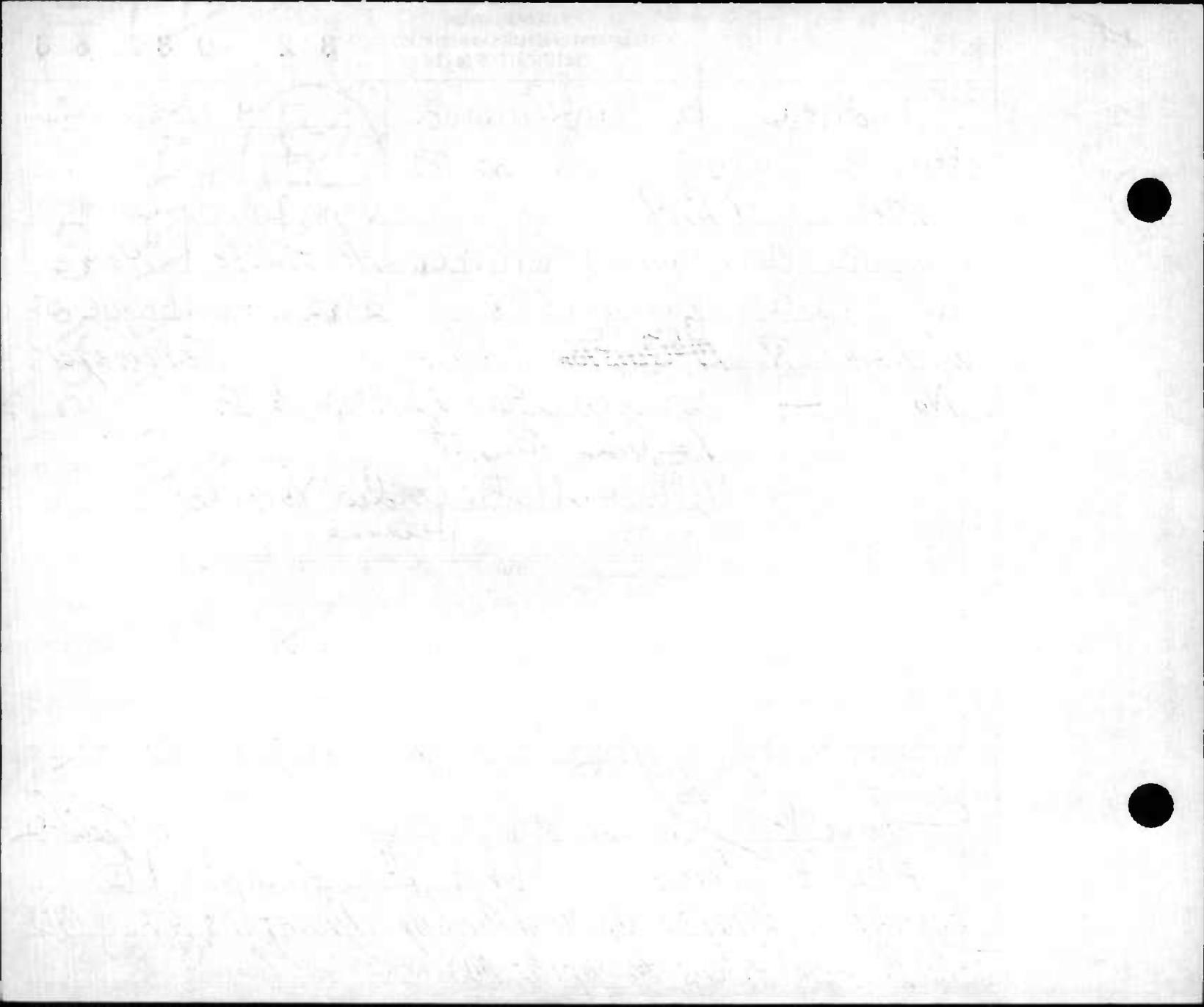
БУРЖИЗИ

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign and return to the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 8 4 3 8 | REG. NO. | | | | |
|--|--|---|--|-------------------------|------|---|--|--------------------------|--|--------------------------------------|----------|--|---|-----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | | | |
| Dorthea B. mcQuiston | | | | | | 4 13 82 | | | 8 2 0 8 4 3 8 | | | 2:25pm | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| female | | white | | MONTH | DAY | YEAR | 84 | | | MONTHS | DAYS | HOURS | MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 | | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MD. | | U.S.A. | | | | | | | | Anne Arundel County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH CITY, GIVE STREET ADDRESS) | | | | | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Annapolis | | Anne Arundel Gen. Hosp. | | | | | | | | | | Housewife | | Home | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | | | | |
| MD. | | a. a. | | Annapolis | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 25-2a King George St. | | | | | |
| 14. FATHER'S NAME | | FIRST | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| William | | R. | | McQuiston | | Feldmeyer | | ANNA | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | |
| No | | 2205600000 | | Edward I. McQuiston Jr. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for item 18a and 18b)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <i>Cordis Cugat</i>
4292
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.
<i>Due to, or as a consequence of,
Hypertension, Cordis-Vonculon
disease</i> | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET | | | CITY OR TOWN | | COUNTY | | STATE | | |
| 22a. I certify that (1) (this hospital) attended the deceased from
since the deceased alive on <i>13 Sept 82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (1) (we) (do) (not) view the body after death. | | | | | | | | | | | | | 19. 80 to 13 Sept 81 | | |
| 22b. SIGNATURE <i>Tom B. Wolfe</i> | | | | | | | | | | | | | 22c. DEGREE <i>MD</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Tom B. Wolfe</i> | | | | | | | | | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | |
| 22e. ADDRESS <i>West St. Annapolis, MD.</i> | | | | | | | | | | | | | 22f. DATE SIGNED <i>14 Oct 82</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE <i>4/16/82</i> | | | 23c. NAME OF CEMETERY OR CREMATORIUM <i>U.S. Naval Academy</i> | | | 23d. LOCATION
CITY OR TOWN <i>Annapolis, A.A.</i> | | | 23e. COUNTY <i>MD.</i> | | | |
| 24. FUNERAL DIRECTOR
NAME <i>John M. Taylor & Sons</i> | | | ADDRESS <i>Annapolis, MD.</i> | | | 25a. DATE REC'D. BY REGISTRAR <i>APR 21 1982</i> | | | 25b. REGISTRAR'S SIGNATURE <i>James J. ...</i> | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 8 4 3 9 | REG. NO. | EST | | | |
|---|--|--|---|--|--|---|--|--|--|---------------|----------|---|--|--|--|
| 1 - FOR
STATE
REGISTRAR | | | 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | | |
| | | | WILLIAM James MEDINGER, JR. | | | | | | APRIL 11, 1982 | | | 2:10 P.M. | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH
MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY)
MONTHS DAYS | | | IF UNDER 1 YEAR IF UNDER 24 HRS
MONTHS DAYS HOURS MIN. | | | |
| Male | | | White | | | Oct. 26, 1919 | | | 62 yrs. | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | |
| Maryland | | | U.S.A. | | | | | | ANNE ARUNDEL COUNTY | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| GLEN BURNIE | | | NORTH ARUNDEL HOSPITAL | | | Auditor | | | State of MD. | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS | | | |
| Maryland | | | A.A. | | | Linthicum | | | | | | 408 Catherine Avenue | | | |
| 14. FATHER'S NAME | | | FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| William | | | J. Medinger, Sr. | | | Myrtle I. Stockett | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT (Wife) | | | ADDRESS | | | Same as | | | |
| Yes | | | W.W. II 217.14.1896 | | | Mrs. Julia E. Medinger | | | | | | # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <i>Congestive heart failure 2 days</i>
<i>4254</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <i>Severe coronary artery disease</i>
(c) <i>Very infected</i> | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>days</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1
<i>99</i> | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET | | | CITY OR TOWN | | | COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased on <i>3/20 1982</i> , to <i>4/11 1982</i> , that (I) (we) last saw the deceased alive on <i>3/20 1982</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22d. DATE SIGNED | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | 7951 OAKWOOD ROAD | | | | | | | | | |
| ANASTACIO E. SUBONG, M.D. | | | | | | GLEN BURNIE, MARYLAND 21061 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION
CITY OR TOWN | | | 23e. STAFF | | | |
| Burial | | | 15 Apr. 82 | | | Cedar Hill Cem. | | | Brooklyn, A.A. Co., MD. | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | | ADDRESS | | | Glen Burnie,
MD. | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Singleton Funeral Home | | | | | | | | | APR 16 1982 | | | <i>James J. Martin</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resigned by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT! If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | 8 2 0 8 4 4 0 | |
|--|--|--|--|--------|------|---|--|--|---|-----------|-----------|---|--|
| | | | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a DATE OF DEATH | | | MONTH | DAY | YEAR | 2b HOUR | |
| <i>MARY McNEIL Melvin</i> | | | | | | <i>4/25/82</i> | | | <i>4</i> | <i>25</i> | <i>82</i> | <i>11:59 PM</i> | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| <i>FEMALE</i> | | | <i>WHITE</i> | | | <i>JULY 17 1920</i> | | | <i>60</i> | | | <input checked="" type="checkbox"/> IF UNDER 1 YEAR
<input type="checkbox"/> MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 | | | 9 | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | |
| <i>New Hampshire</i> | | | <i>U.S.A.</i> | | | <i>MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></i> | | | <i>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></i> | | | <i>Anne Arundel</i> | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(NOT A TOWN, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | |
| <i>Annapolis</i> | | | <i>995 Melvin Road</i> | | | <i>Homemaker</i> | | | <i>Home</i> | | | | |
| 13a. STATE
<i>MD.</i> | | | 13b. COUNTY
<i>Anne Arundel</i> | | | 13c. CITY OR TOWN
<i>Anne Arundel Annapolis</i> | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS
<i>995 Melvin Road</i> | |
| 14. FATHER'S NAME
FIRST | | | MIDDLE | | | 15. MOTHER'S MAIDEN NAME
FIRST | | | LAST | | | | |
| <i>Harry</i> | | | <i>McNeil</i> | | | <i>Jane</i> | | | <i>Hayes</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | |
| <i>No</i> | | | <i>003-10-9375</i> | | | <i>Ridgely P. Melvin #13</i> | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| <i>1629</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
b) <i>metastasis to bone,</i> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
c) <i>liver + brain</i> | | | | | | | | | | | | <i>8+ mon</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).
<i>Hypertension</i> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>2/82</i> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Biopsy of liver</i> | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR
P.M. <input type="checkbox"/> 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET <input type="checkbox"/> CITY OR TOWN <input type="checkbox"/> COUNTY <input type="checkbox"/> STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/16/81</i> to <i>4/25/82</i> , that (I) (we) last saw the deceased alive on <i>4/29/82</i> , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | | 22b. DATE SIGNED
<i>4-26-82</i> | |
| 22c. SIGNATURE
<i>Frank M. Shifley MD</i> | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>F M SHIFLEY</i> | | | 22e. DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
TOMBS
<i>CREMATION</i> | | | 23b. DATE
<i>4/27/82</i> | | | 23c. NAME OF CEMETERY OR CREMATORIUM
<i>FORT LINCOLN CEM.</i> | | | 23d. LOCATION
STREET <input type="checkbox"/> CITY OR TOWN <input type="checkbox"/> COUNTY <input type="checkbox"/> STATE | | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Sohn M. Taylor, Sons Awansous MD.</i> | | | 25a. CERTIFIED BY DIRECTOR
NAME
<i>John M. Taylor, Sons Awansous MD.</i> | | | 25b. DATE
<i>4/26/82</i> | | | 25c. RELEASER'S SIGNATURE | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 8208441 | | |
|---|---------|------------------------------------|--|----------------------------------|----------------------------------|---|--|--|---|-----|------|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN
OF ESTI-
DEATH MATED | | | MONTH | DAY | YEAR | 2b. HOUR | | |
| Thomas J. Nelson | | | | | | <input checked="" type="checkbox"/> | | | 4 | 29 | 1982 | A M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | 6. AGE (IN YEARS
LAST BIRTHDAY)
YRS. | 7. IF UNDER 1 YR.
MONTHS DAYS | 8. IF UNDER 24 HRS.
HOURS MIN | 2c. DATE
PRONOUNCED
DEAD | | | MONTH | DAY | YEAR | 2d. HOUR | | |
| M | NZ | 5 7 28 54 | 54 | | | <input checked="" type="checkbox"/> | | | 4 | 29 | 1982 | A M | | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| AA CO MD | | | USA | | | | | | A. A. CO | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | |
| Green Bowie | | | North. General Hospital. | | | Laborer | | | Bricklayer | | | | | |
| 13a. STATE
MD | | | 13b. COUNTY
B.A. | | | 13c. CITY OR TOWN
Pasadena | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
8134 Nogalee Rd | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT
ADDRESS | | |
| Fountain Nelson | | | Sedonia Johnson | | | YES | | | 220-24-7870 | | | Karie H. 8134 Nogalee Rd | | |
| 4292 | | | Korean | | | PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) | | | Conditions caused disease | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| Conditions, if any, which
gave rise to immediate
cause (a) starting the under-
lying cause last. | | | DUE TO, OR AS A CONSEQUENCE OF | | | (b) | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | | | | | | |
| | | | | | | <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION
STREET | | | CITY OR TOWN | | | COUNTY STATE | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion
death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | | TITLE (SPECIFY) | | | M.D. <i>Report</i> | | | MEDICAL EXAMINER | | | DATE SIGNED <i>4.29.82</i> | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | | | | ADDRESS | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE
5/3/82 | | | 23c. NAME OF CEMETERY OR CREMATORIAL
MATERIALS | | | 23d. LOCATION
CITY OR TOWN
Pasadena | | | COUNTY MD | | |
| 24. FUNERAL DIRECTOR
<i>Marschall Funeral Home</i> | | | | | | | | | STATE | | | | | |
| | | | | | | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR
APR 30 1982 | | | 25b. REGISTRATION NUMBER
<i>Home Health</i> | | | | | | | | | | | |

1180 16

Hilma Gruber 1881 18 99A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | 8208442 | | | | | |
|---|--|--|--|--|--|---|--|--|--|--|--|--|--|--|------------------------------------|--|--|
| | | | | | | | | | | | | REG. NO. | | | | | |
| 1. FOR
STATE
REGISTRAR | | | 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | | | |
| BARBARA C. NIEDRINGHAUS | | | | | | | | | | | | | | | | | |
| 3. SEX
FEMALE | | | 4. RACE
CAUCASIAN | | | 5. DATE OF BIRTH
MONTH
3 DAY
8 YEAR
16 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
MONTHS
66 YRS. | | | 7b. HOUR
4-26-82 10:30 P.M. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pa. | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co | | | 10. IF UNDER 1 YEAR
MONTHS
DAYS | | | | | |
| 11. CITY OR TOWN OF DEATH
Minneapolis | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY
MD. | | | | | | | | |
| 13a. STATE
Md. | | | 13b. COUNTY
A.A. | | | 13c. CITY OR TOWN
Minneapolis | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
210 Rugby Road | | | | | |
| 14. FATHER'S NAME
FIRST
Phillip | | | MIDDLE
S. | | | Arnold | | | 15. MOTHER'S MAIDEN NAME
FIRST
Marion | | | LAST
Sheridan | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
168-03-7431 | | | 16c. INFORMANT
Mr. John M. Niedringhaus | | | 17. ADDRESS
Arnold, Md. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intracerebral hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
(b) Hypertensive vascular disease .
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days- | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
4/23 | | | 21f. LOCATION
STREET
4/23 | | | CITY OR TOWN
1982 | | | COUNTY STATE
4/26 1982 | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 4/26 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | | 22b. SIGNATURE
John M. Niedringhaus | | | | | |
| 22c. DEGREE
MD | | | | | | | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22d. DATE SIGNED
4/27/82 | | |
| 22e. ADDRESS | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | | 23b. DATE
4/27/82 | | | 23c. NAME OF CEMETERY OR CREMATORIAL
Balto., Md. | | | 23d. LOCATION
CITY OR TOWN
COUNTY STATE | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR
APR 30 1982 | | | 25b. REGISTRAR'S SIGNATURE
James J. Nestor | | | | | | | | |

S 1, 50 26



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

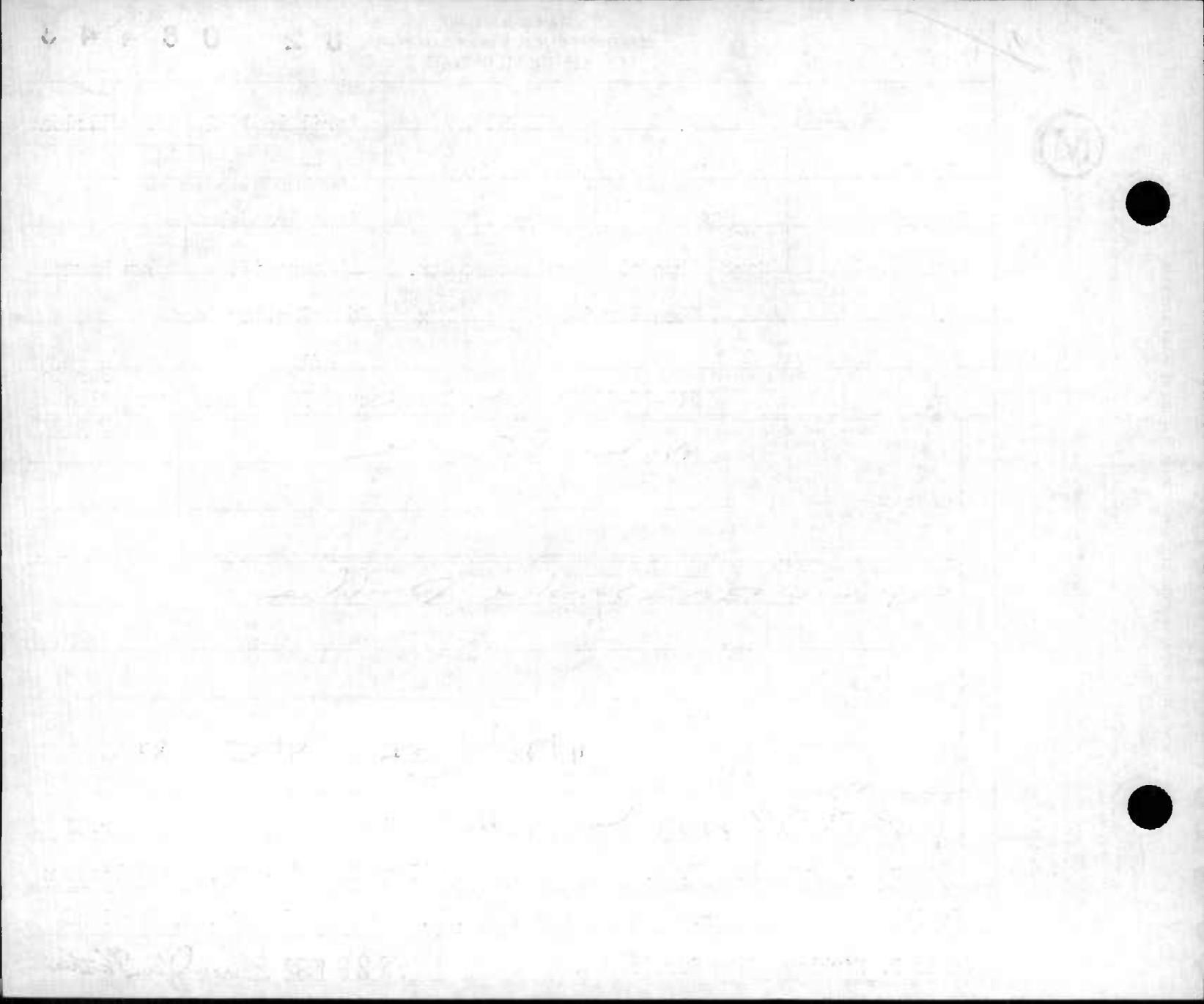
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event the medical examiner must be advised.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 0 8 4 4 3

REG. NO.

| | | | | | | | | | | | |
|---|--|---|-------|---|------|---|--------------------------------------|---|------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | |
| ANNA | | | M. | NILSSON | | April 26, 1982 | | | | 11:15a M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH
MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| Female | | White | | July 22, 1904 | | | 77 YRS | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Kentucky | | USA | | | | | Anne Arundel | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Glen Burnie | | North Arundel Convalescent Ctr. | | | | | Housewife | | | Own Home | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | | |
| Md. | | AA | | Glen Burnie | | | | 6664 Shelley Road | | | |
| 14. FATHER'S NAME
FIRST | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME
FIRST | | MIDDLE | | LAST | |
| N/A | | | | | | | | N/A | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 16c. INFORMANT | | 17. ADDRESS | | Burnie | | | |
| No | | 213-10-9564D | | Mrs. Rose Mack, 6670 Roberts Court, Glen | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Natural Cause</i> | | | | | | | | | | | |
| APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| 3109
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.
(b) _____
DOUE TO, OR AS A CONSEQUENCE OF
(c) _____
DOUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).
<i>Onset Brain Syndrome, Guillain</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4/26/82</i> , 1982, to <i>4/25/82</i> , 1982, that (I) (we) lost
saw the deceased alive on <i>4/1/82</i> , 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Robert B. Kroopnick</i> | | DEGREE
MD | | 22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22d. DATE SIGNED
26 Apr. 82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | |
| Robert B. Kroopnick, M. D. | | Liberty Plaza Shopping Ctr., Randallstown | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
28 Apr. 82 | | 23c. NAME OF CEMETERY OR CREMATORIAL
Glen Haven Mem.Pk. | | 23d. LOCATION
Glen Burnie, AA, Maryland | | 25a. DATE REC'D. BY REGISTRAR
Apr 29 1982 | | | |
| 24. FUNERAL DIRECTOR
NAME
James S. Kirkley, Glen Burnie, Md. | | ADDRESS | | | | | | 25b. REGISTRAR'S SIGNATURE
<i>James S. Kirkley</i> | | | |

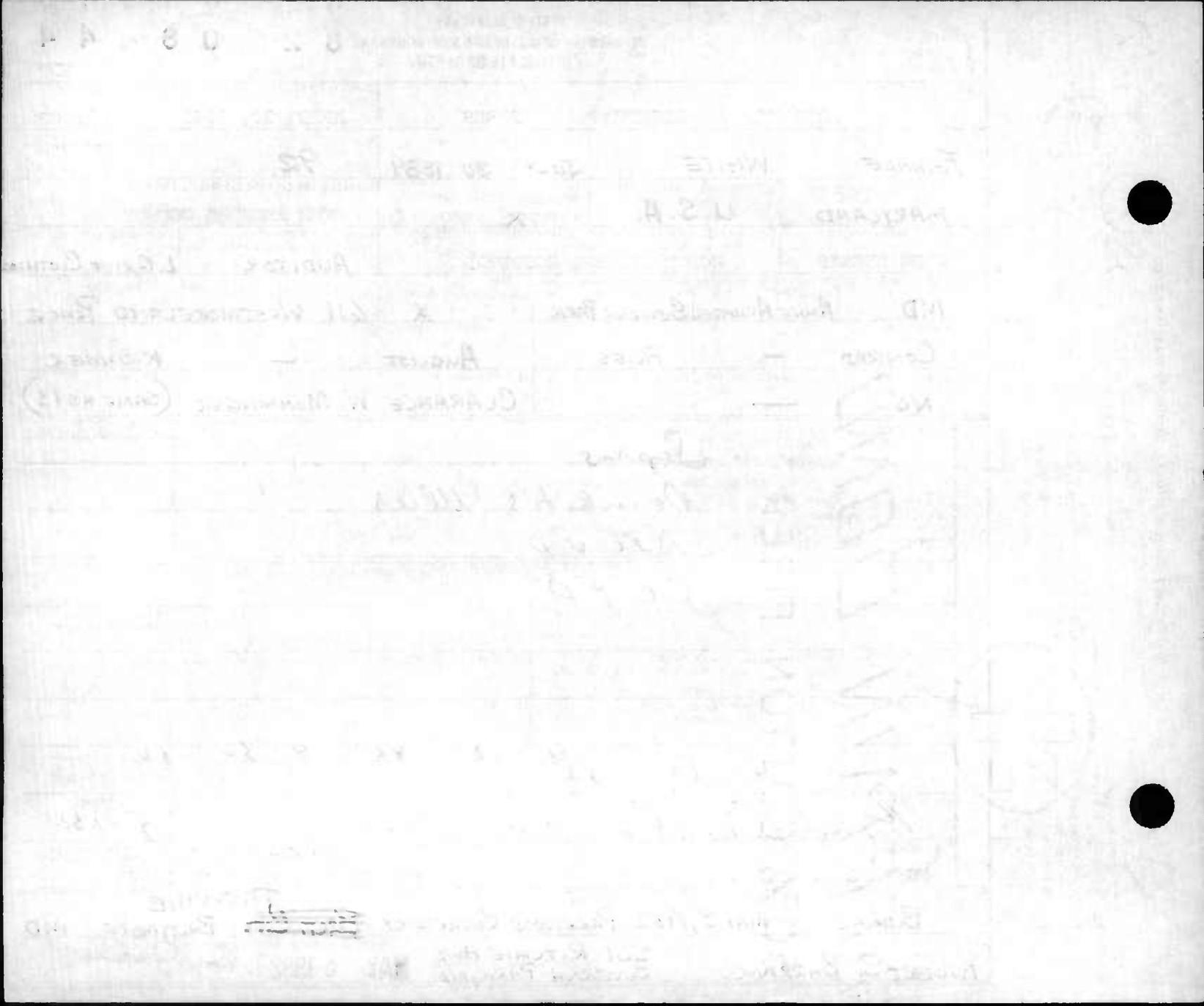


TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 8 4 4 4 | | |
|--|--|--|--|----------------------|---|--|--|--|--|--|-------|--|
| | | | | | | | | | | REG. NO. | | |
| 1 - STATE REGISTRAR | | | 2a DATE OF DEATH MONTH DAY YEAR | | | | | | | 2b HOUR | | |
| I. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | | APRIL 30, 1982 | | | 1:00 P M | | |
| KATHRYN LIZETTA PARKS | | | | | | | | | | | | |
| 3. SEX
FEMALE | | | 4 RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
JULY 30 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY)
92 | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
AUDITOR | | | 12b. KIND OF BUSINESS OR INDUSTRY
L.GRIEF CLOTHING | | | | |
| 13a. STATE
MD. | | | 13b. COUNTY
ANNE ARUNDEL | | 13c. CITY OR TOWN
SEVERNA PARK | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS
611 WESTMORELAND Place | | |
| 14. FATHER'S NAME
FIRST
CONRAD | | | MIDDLE
— | LAST
FRIES | 15. MOTHER'S MAIDEN NAME
FIRST
AUGUST | | | MIDDLE
— | LAST
KRAMER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
— | | 17. INFORMANT
CLARANCE W. MONNINGER | | | ADDRESS
(SAME AS 13) | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis
4292
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause first.
Decubitis Ulcer | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Decubitis Ulcer | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) COPD | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
COPD | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-12 1982 to 4-30 1982 , that (I) (we) last saw the deceased alive on 4-30 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED
5-1-82 | | |
| 22b. SIGNATURE
Mustafa Oz, M.D. | | | 22c. DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MUSTAFA C. OZ, M.D. | | | 22e. ADDRESS
605 BALTIMORE-ANNAPOLIS BOULEVARD
GLEN BURNIE, MARYLAND 21061 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
MAY 3, 1982 | | 23c. NAME OF CEMETERY OR CREMATORIAL
PARKWOOD CEMETERY | | 23d. LOCATION
CITY BALTIMORE STATE MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME
ROBERT S. BARRANCO | | | 25a. DATE REC'D. BY REGISTRAR
MAY 5 1982 | | 25b. REGISTRAR'S SIGNATURE
Amelia | | | | | | | |
| DHMH-16 50M 1/81
(VRA 15, 4) | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 82 08445 | | | |
|---|--|--|---|---|--|---|--|---|--|---|-------------------|-----------------|------|
| | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | |
| Theodore - | | | Patrick (Petryk) | | | 04 06 82 | | | | | 82 | 08445 | |
| 3. SEX | | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Male | | | Cauc. | | MONTH 2 DAY 20 YEAR 95 | | 87 YRS. | | | MONTHS | DAYS | HOURS | MIN. |
| 7a. BIRTHPLACE
COUNTRY | | | 7b. CITIZEN OF WHAT COUNTRY? | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | |
| Austria Hungary | | | U.S. A. | | | | Anne Arundel | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH A CITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Glen Burnie | | | Maryland Manor Nursing Home | | Riveter | | | Car Factory | | | | | |
| 13a. STATE | | | 13b. COUNTY | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS | | | 14. FATHER'S NAME | | |
| Maryland | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 1619 Church Street | | | FIRST Unknown | | |
| 15. MOTHER'S MAIDEN NAME | | | ADDRESS | | | | LAST | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
(IF YES, GIVE WAR OR DATES) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| NO | | | 214-56-0793 | | | Mrs. Mary P. Clemens 108 W. 11th Ave. 21225 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) ASCVD & multiple CVA's | | | | | | | | | | | | | |
| 4592 | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET | | CITY OR TOWN | | COUNTY | | STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Peter H. Rheinstein, MD</i> | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> | | MEDICAL DIRECTOR <input checked="" type="checkbox"/> | | STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
4/6/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>PETER H. RHEINSTEIN, MD</i> | | 22e. ADDRESS | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
4-8-82 | | 23c. NAME OF CEMETERY OR CREMATORIAL
Holy Cross Cemetery | | 23d. LOCATION
CITY OR TOWN
Baltimore Anne Arundel | | COUNTY | | STATE | | | |
| 24 FUNERAL DIRECTOR
NAME
McCullly F.H. et Cottis Bay | | 25a. DATE REC'D. BY REGISTRAR
APR 8 1982 | | 25b. REGISTRATION NUMBER
4200 Pennington Avenue | | 25c. DATE OF DEATH
21226 | | | | | | | |

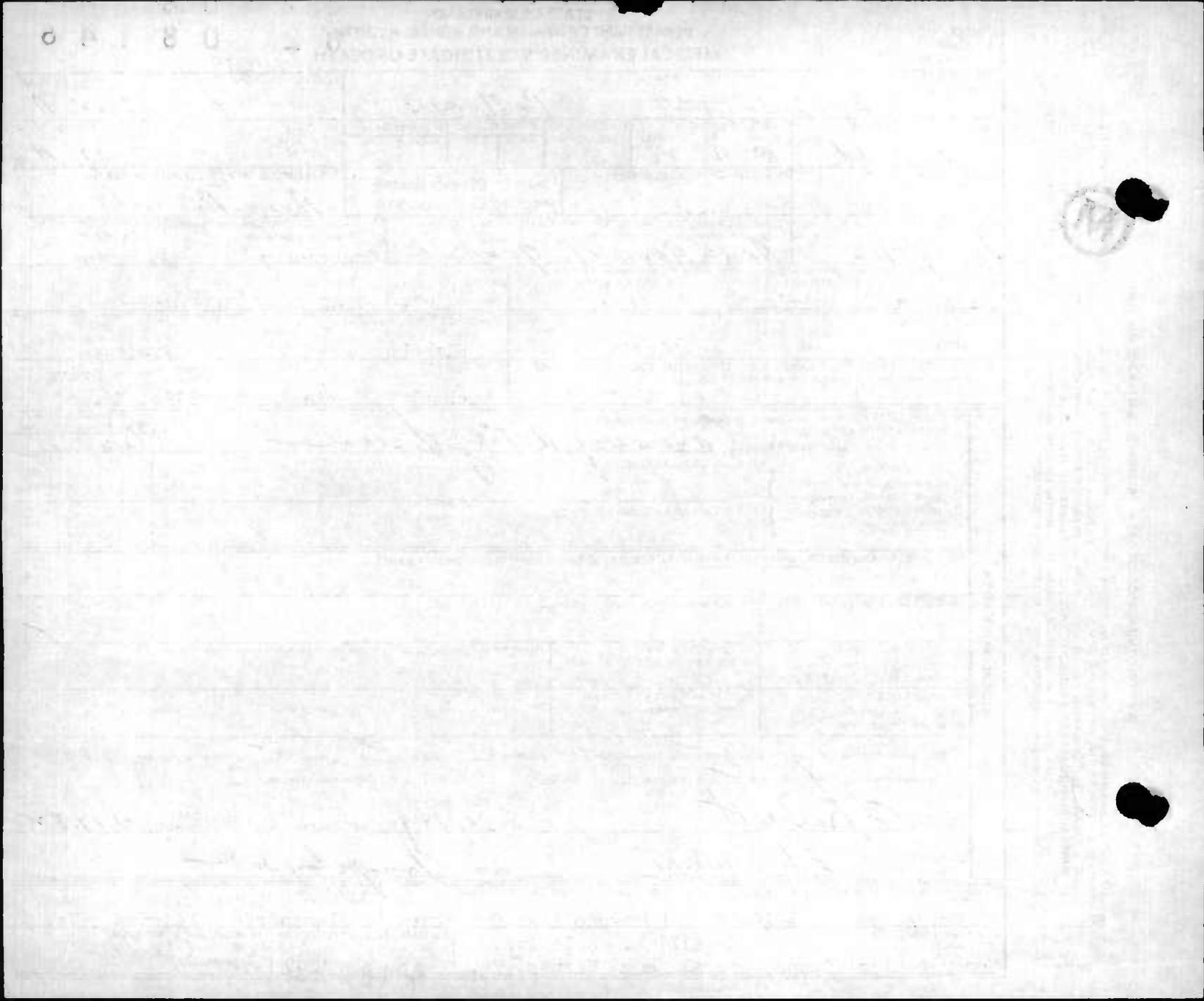
C P R S U - S M A R T S C H

waterfall, and the water falls over a rocky ledge.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEFICIENCIES ARE FOUND, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 2 0 8 4 4 6 | | |
|---|-----------|------------------------------------|--|-------------------------|---|---|--|----------------------|--|---|------|--|--------------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN
OF ESTI-
DEATH MATED | | | MONTH | DAY | YEAR | 2b. HOUR | | |
| <i>EUClid Maurice</i> | | | | | <i>Pellerin</i> | <i>4/17/1982 A M</i> | | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | 6. AGE (IN YEARS
LAST BIRTHDAY) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 2c. DATE
PRONOUNCED
DEAD | | | MONTH | DAY | YEAR | 2d. HOUR | | |
| <i>M</i> | <i>14</i> | <i>10 12 29</i> | <i>52 yrs.</i> | MONTHS | DAYS | HOURS | MIN. | <i>4/17/1982 A M</i> | | | | | | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| <i>Connecticut</i> | | <i>U.S.A.</i> | | | | | | | <i>Anne Arundel.</i> | | | | | |
| 10. CITY/TOWN OF DEATH | | | | | | | | | | | | MD. | | |
| <i>Annapolis Anne Arundel, Maryland</i> | | | | | | | | | | | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS
OR INDUSTRY | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS | | | | | |
| <i>Virginia</i> | | <i>Fairfax</i> | | <i>McLean</i> | | | | | <i>7008 Hamel Hill Court</i> | | | | | |
| 14. FATHER'S NAME
FIRST | | MIDDLE | | LAST | 15. MOTHER'S MAIDEN NAME
FIRST | | | MIDDLE | | LAST | | | | |
| <i>Ovid</i> | | | | <i>Pellerin</i> | <i>Blanche</i> | | | | | <i>Brodeur</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | ADDRESS | | | 18. APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | |
| <i>No</i> | | <i>047-22-5226</i> | | <i>Michael Pellerin</i> | | | <i>425 Ross Drive</i> | | | <i>None</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>coronary artery disease</i> | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lost. | | | | | | | | | | | | | | |
| (b) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | 20. AUTOPSY? | | |
| | | | | | | | | | | | | <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION
STREET | | | CITY OR TOWN | | | COUNTY | STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE <i>E. L. Brodeur</i> | | | TITLE (SPECIFY) <i>M.D.</i> | | | MEDICAL EXAMINER <i>Deputy</i> | | | DATE SIGNED <i>4.17.82</i> | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) <i>E. L. Brodeur</i> | | | ADDRESS <i>Annapolis, Md.</i> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) <i>Cremation</i> | | | 23b. DATE <i>4-19-82</i> | | | 23c. NAME OF CEMETERY OR CREMATORIAL <i>Metropolitan Crematory</i> | | | 23d. LOCATION
CITY OR TOWN <i>Alexandria</i> | | | COUNTY <i>Fairfax</i> | STATE <i>Va.</i> | |
| 24. FUNERAL DIRECTOR
NAME <i>Money & King Vienna Funeral Home</i> | | | ADDRESS <i>171 W. Maple Ave.</i> | | | 23e. DATE REC'D. BY REGISTRAR <i>APR 22 1982</i> | | | 23f. REGISTRAR'S SIGNATURE <i>John J. Martin</i> | | | | | |
| BP | | DHMH - 17
(VR A15 ME (5)) | | 15M 7/77 | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the time it is issued with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | 8208447 | | | | | |
|--|--|--|---|--------|-------------------|---|---|-------------------------------------|---|--------------------------------|-------|--|--|--|-----------------------------------|--|--|
| | | | | | | | | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | | | | | |
| <i>Chester ARTHUR Perego Jr.</i> | | | | | | 4 29 82 | | | | | 12 PM | 26 | | | | | |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH | MONTH | DAY | YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | | | | |
| Male | | | White | | 2 29 | | 04 | 78 | 78 | | | IF UNDER 24 HRS | | | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | NEVER MARRIED | <input type="checkbox"/> | <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | YRS. | | | | | |
| OHIO | | | U.S.A. | | WIDOWED | DIVORCED | <input type="checkbox"/> | <input type="checkbox"/> | <i>Anne Arundel Co</i> | | | MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| <i>Annapolis</i> | | | <i>Anne Arundel Gen. Hosp.</i> | | | | | | | | | <i>Farming</i> | | | <i>Rkt.</i> | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | | | | | | |
| MD | | | AA. | | <i>Annapolis</i> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | <i>1545 Cedar Lane Swan Rd</i> | | | | | | | |
| 14. FATHER'S NAME | | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | | MIDDLE | LAST | | | | | | | |
| <i>CHESTER A</i> | | | <i>Perego</i> | | | <i>ANNA</i> | | | <i>Von GLEICH</i> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | | | | | |
| NO | | | 218-32-3704 | | | KATHERINE B. PEREGO #13 | | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | |
| IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> | | | | | | | | | | | | 1 hour | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Cardiac arrest</i> | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21d. INJURY OCCURRED
<i>AT HOME</i> | | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM ETC.) | | | 21f. LOCATION
STREET | | | CITY/TOWN | | | COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4/29/82</i> , to <i>4/29/82</i> , that (I) (we) lost
now the deceased alive on <i>4/29/82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I/we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Richard N. Peeler</i> | | | | | | | | | | | | 22c. DEGREE | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | ATTENDING PHYSICIAN <input type="checkbox"/> | | | MEDICAL DIRECTOR <input type="checkbox"/> | | | STAFF PHYSICIAN <input type="checkbox"/> | | | | | |
| <i>RICHARD N. PEELER</i> | | | <i>121 CATHEDRAL St. Annapolis MD.</i> | | | | | | | | | <i>4/29/82</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(CITY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIUM | | | 23d. LOCATION
CITY/TOWN | | | COUNTY STATE | | | | | |
| Burial | | | 5/2/82 | | | St. MARGARET Cem. | | | St. MARGARET | | | Annapolis MD. | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |
| <i>John M. Taylor Sons Annapolis MD.</i> | | | | | | MAY 5 1982 | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | 8 2 0 8 4 4 8 | | |
|---|--|--|---|--------|---|---|--|-------------|--|-------------------------------------|---------------------|------------------|-----------|------|
| | | | | | | | | | | | | REG. NO. | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a DATE OF DEATH | | | MONTH | DAY | YEAR | 2b HOURS | | |
| Leon E Peterson | | | | | | 4 20 82 | | | 4 | 35 | 4 35 | | | |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| Male | | | White | | MONTH DAY YEAR
10-4-06 | | 75 | | | YRS | MONTHS | DAYS | HOURS | MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b CITIZEN OF WHAT COUNTRY? | | 8 | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Unobtainable | | | USA | | 8 | | | | | Anne Arundel | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Annapolis | | | Anne Arundel Hospital | | Carpenter (R) | | Construction | | | | | | | |
| 13a STATE | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e STREET ADDRESS | | | | |
| MD | | | A.A. | | Davidsonville | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 1224 Sandalwood Rd. | | | | |
| 14. FATHER'S NAME | | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | | FIRST | MIDDLE | LAST | | | |
| | | | Ludwig | | Peterson | Anna | | | Jenson | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17 INFORMANT | | | ADDRESS | | | | | | |
| No | | | 53512 6017 | | Shirley Roach | | | Harwood Md. | | | 1224 Sandalwood Rd. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY: | | | IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | |
| 4360 | | | DUE TO, OR AS A CONSEQUENCE OF
(b) | | | 17 Hours | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1o | | | | | | | | | | | | | | |
| PREVIOUS CVA - 1963 WITH SEIZURE DISORDER. | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.) | | | 21f LOCATION
STREET | | | CITY OR TOWN | | | COUNTY | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 0-2 19 79 to 4-20 19 82, that (we) last saw the deceased alive on 3-22 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We did not view the body after death.) | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| Dr. Edward S. Beck | | | 1616 Forest Drive | | | Annapolis, Md 21403 | | | | | | 4/21/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION
CITY OR TOWN | | | COUNTY | STATE | |
| Burial | | | 4/23/82 | | | National Memorial Park | | | Falls Church, Virginia | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | Cameron & Alfred Sts. | | | DATE REC'D. BY REGISTRAR | | | REGISTRAR | SIGNATURE | |
| Cunningham Funeral Home, Inc. Alex., Va. | | | | | | | | | APR 26 1982 | | | James J. Martin | | |

1958.05.12

1958.05.12. no. 1

1958.05.12. 1958.05.12.

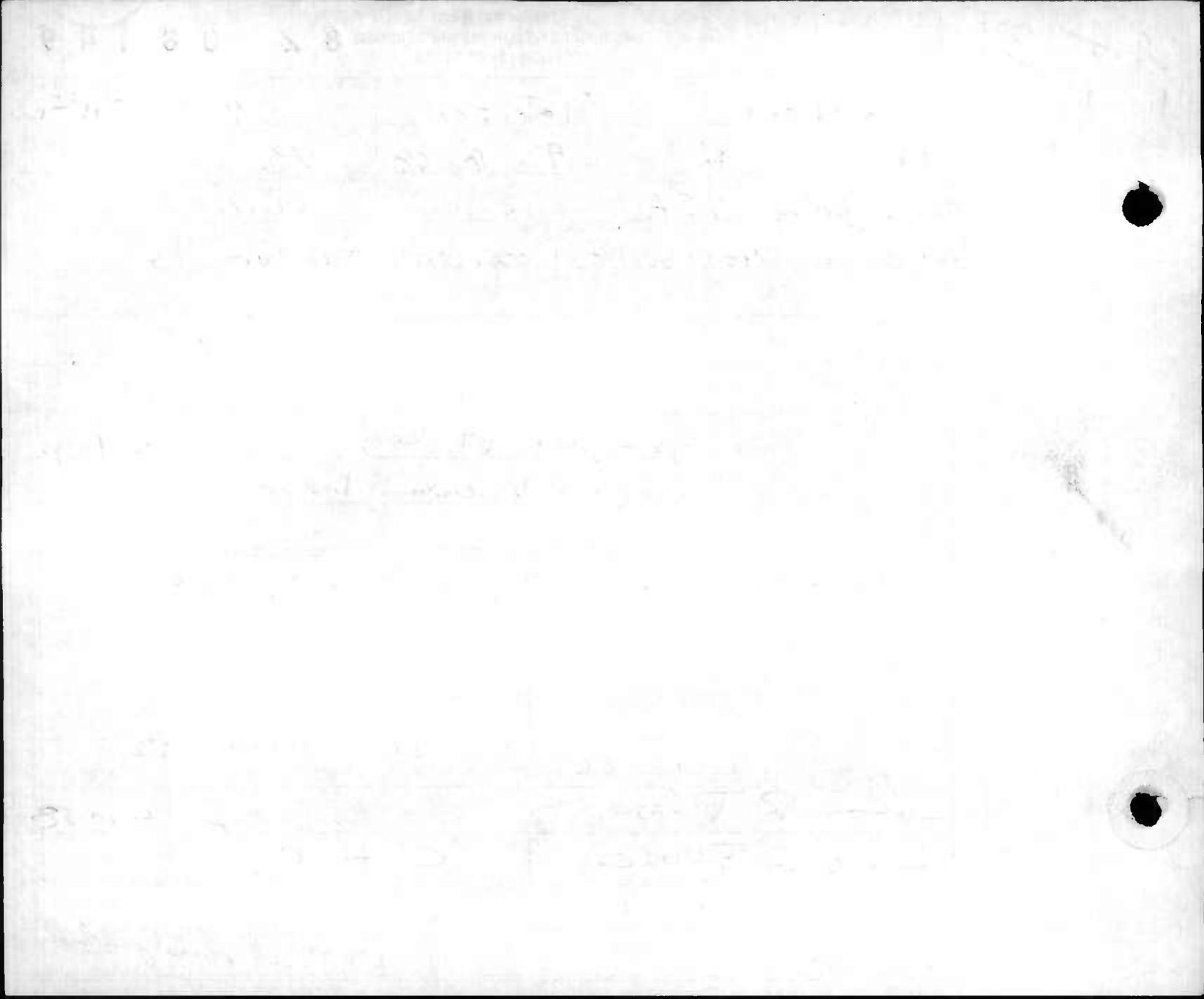
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1958.05.12. 1958.05.12.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | 8208449 | | | |
|---|--|--|---|-----------------|----------|---|---------------------------------|--|---|-----------------|---|-----------------|--------------------------------------|------|--|
| 1. FOR
STATE
REGISTRAR | | | | | | | | | | | REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2d. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | | | |
| Richard | | | | | Peterson | 4/10/82 | | | 11:20 P.M. | | | | | | |
| 3. SEX | | | 4 RACE | 5 DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| M | | | N | 9 | 9 | 09 | 72 | | | YRS. | MONTHS | DAYS | HOURS | MIN. | |
| 7a. BIRTHPLACE
COUNTRY | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 | | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| South Carolina | | | USA | | | | | | | | | | A.A. cd | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Crownsville | | | Crownsville Hosp. Center | | | Janitor | | | | | | | | | |
| 13a. STATE
MD | | | 13c. CITY OR TOWN
Baltimore | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
1115 N. Collington Avenue | | | | | | |
| 14. FATHER'S NAME
FIRST William | | | LAST Benjamin | | | 15. MOTHER'S MAIDEN NAME
FIRST Julia | | | LAST Benjamin | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO
No 247-26-5499 | | | 17. INFORMANT
Bernice James 1115 N. Collington Ave. | | | ADDRESS | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Gangrene RT leg</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Benign Vascular Disease</u>
5 days
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause, lost | | | | | | | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Dementia deet Organi B.rn Systemic</u> | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 19b. YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20a. YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET | | | CITY OR TOWN | COUNTY | STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-10, 1982, to 4-10, 1982, that (I) (we) last
saw the deceased alive on 4-10, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) did not view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Luis R. Flores</u> | | | 22c. DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22d. DATE SIGNED
4-10-82 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Luis R. Flores | | | 22e. ADDRESS
C.H.C. | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
4/16/82 | | | 23c. NAME OF CEMETERY OR CREMATORIAL
Eastview Mem. Pk. | | | 23d. LOCATION
CITY OR TOWN
Baltimore | | | COUNTY | STATE
MD | | |
| 24. FUNERAL DIRECTOR
NAME
Wm. C. March F/H | | | ADDRESS
1101 E. North Ave. | | | 25a. DATE REC'D. BY REGISTRAR
APR 12 1982 | | | 25b. REGISTRAR'S SIGNATURE
<u>Name Jan Harter</u> | | | | | | |
| 0804 BP | | | | | | | | | | | | | | | |
| DHMH - 16 60M 1/75
(VR A 15 (4)) | | | | | | | | | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES. PAGE 2 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | 3 2 0 8 4 5 0 | REG. NO. | |
|---|---------|------------------------------------|--|-------------------------------|--------------------------------|---|--|--|---|--|-----|---|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN
OF
DEATH MATED | | | | MONTH | DAY | YEAR | 2b. HOUR | |
| Sherman Albert POWELL | | | | | | <input checked="" type="checkbox"/> 4-29-82 | | | | 19 | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | 6. AGE (IN YEARS
LAST BIRTHDAY) | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE
PRONOUNCED
DEAD | | | | MONTH | DAY | YEAR | 2d. HOUR | |
| male | white | July 31, 18 | 63 yrs. | | | <input checked="" type="checkbox"/> 4-29-82 | | | | 19 | | | 12:55 DM | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Pennsylvania | | | U.S.A. | | | | | | | Anne Arundel County | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | |
| Glen Burnie | | | North Arundel Hospital | | | MSGT E7. (Ret.) | | | | U.S. ARMY | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS | | | | |
| Maryland | | | Anne Arundel | | | Glen Burnie | | | | 116 Furnlea Drive | | | | |
| 14. FATHER'S NAME
FIRST | | | MIDDLE | | | LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST | MIDDLE | | | LAST | |
| Roy | | | | | | Powell | | | Louise | | | | Williams | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT (Son) ADDRESS | | | | 711 Brookwood | | | | |
| YES | | | 1939 - 1962 | | | Mr. Gary A. Powell-Rd.Balto., MD. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)
9109 Drowning
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | | | | | | |
| | | | | | | <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOOR A.M. MONTH DAY YEAR
? P.M. 4-29-82, | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
subject found in water | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE
AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)
creek | | | 21f. LOCATION
STREET
Bodkins Creek CITY OR TOWN
Anne Arundel Co., Maryland COUNTY
Maryland STATE | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion
death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | DATE SIGNED 4-29-82 | | |
| ACTUAL SIGNATURE Virginia L. Dolan
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. ADDRESS 111 Penn Street | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIUM | | | | 23d. LOCATION
CITY OR TOWN
Crownsville, A.A. MD. | | | | |
| Burial | | | 3' May 82 | | | MD. Veterans Cem. | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| J. Easter | | | Glen Burnie,
MD. | | | MAY 3 1982 | | | | Frances Jan Kather | | | | |
| Singleton Funeral Home | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | 8208451 | | | | |
|--|--|--|--|-----------------------------|--------------|--|--|--|---|----------|---------|---|-----------------|---|---------------|
| 1 - STATE REGISTRAR | | | BERTHA REVELL | | | REVERE | | | 2a DATE OF DEATH | | | MONTH | DAY | YEAR | 2b HOUR |
| 1 DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | Bertha Revelle | | | 4-11-82 | | | | | | 7:30 AM |
| 3a SEX | | | F | RACE | W | 5 DATE OF BIRTH
MONTH 01 DAY 26 YEAR 1893 | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | IF UNDER 24 HRS | | |
| 7a BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | | Maryland | 7b CITIZEN OF WHAT COUNTRY? | USA | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | 10 CITY OR TOWN OF DEATH | | | MD. |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | Annapolis Convalescent Center | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | Housewife | | | 12b KIND OF BUSINESS OR INDUSTRY | | | Home |
| 13a STATE | | | Md | 13b COUNTY | Anne Arundel | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e STREET ADDRESS | | | 14 CITY OR TOWN | | | Box 17 |
| 14. FATHER'S NAME | | | Charles | MIDDLE | Last | 15. MOTHER'S MAIDEN NAME | | | James R Revell | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | Friendship Md |
| | | | | | | 16b SOCIAL SECURITY NO. | | | | | | 17. INFORMANT | | | ADDRESS |
| | | | NO | | | Funk | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Brain tumor (probable meningioma) | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| 2052
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
none | | | | | | | | | | | | | | | |
| 21a MEDICAL CERTIFICATION | | | 21b DATE OF OPERATION | | | 21c CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? | | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | - | | | - | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21d ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSED BY <input checked="" type="checkbox"/>
(IF EITHER, NOTIFY MEDICAL DIRECTOR) | | | 21e TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. N/A 19 | | | 21f HOW INJURY OCCURRED
N/A | | | 21g NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2
N/A | | | | | | |
| 21h INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>
N/A | | | 21i PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
N/A | | | 21j LOCATION
STREET N/A CITY OR TOWN 4711 COUNTY 82 STATE | | | | | | | | | |
| 22a I certify that (1) this hospital attended the deceased from 4/11/82 to 4/11/82, that (1) we last saw the deceased alive on 4/11/82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) we (did) (did not) view the body after death. | | | | | | | | | | | | | | 27a DATE SIGNED | |
| 22b SIGNATURE
Thomas Walsh MD | | | | | | | | | | | | | | 27b DATE SIGNED | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22f ADDRESS | | | 22g COUNTY | | | 22h STATE |
| THOMAS M WALSH MD | | | MD | | | Thomas Walsh | | | 269 Peninsula Farm Rd | | | Annon | | | Md. |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b DATE | | | 23c NAME OF CEMETERY OR CREMATORIAL
ADDRESS | | | 23d LOCATION
CITY OR TOWN FRIENDSHIP CHURCH FRIENDSHIP MD | | | 23e COUNTY | | | 23f STATE |
| Burial | | | 4-14-82 | | | Friendship Church, MD | | | | | | | | | |
| 24 FUNERAL DIRECTOR
NAME | | | 24a ADDRESS | | | 24b DATE REC'D. BY REGISTRAR | | | 24c REGISTRAR'S SIGNATURE | | | | | | |
| Rausch Funeral Home | | | Annon | | | APR 15 1982 | | | John J. ... | | | | | | |

12.80 10

20 Aug 1967 Level on road
Johnston - 200' - 200'
and about 200' above sea level
at 8:00 A.M. - road 64 ft. b.t.
- 100' - road 200'
at the same level road
about 100' above sea level
at 8:00 A.M. - road 64 ft. b.t.
- 100' - road 200'
at the same level road
about 100' above sea level
at 8:00 A.M. - road 64 ft. b.t.
- 100' - road 200'
at the same level road
about 100' above sea level
at 8:00 A.M. - road 64 ft. b.t.
- 100' - road 200'

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | 8 2 0 8 4 5 2 | | |
|--|--|--|--|--------------------------------|--|---|---|--------|---|---|-------|---|------|--|
| | | | | | | | | | | | | REG. NO. | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2d. DATE OF DEATH | | | MONTH | DAY | YEAR | 2d. HOUR | | |
| WILLIAM J. | | | | | RICE | 4-23-82 | | | 12 | noon | | M. | | |
| 3. SEX | | | 4. RACE | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| MALE | | | Negro | 12-06-09 | | | 72 | | | MONTHS | DAYS | HOURS | MIN. | |
| 7e. BIRTHPLACE
COUNTRY
MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel Hospital | | | 12d. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
ANNAPOLIS | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
1208 Barbud Lane | | | | |
| 14. FATHER'S NAME
FIRST JAMES | | | MIDDLE | LAST RICE | 15. MOTHER'S MAIDEN NAME
FIRST JEAN | | | MIDDLE | LAST EMERSON | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS
VIOLA RICE 1208 Barbud La. Annapolis, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

1890
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause, lost.

DUE TO, OR AS A CONSEQUENCE OF
Metastatic Lung Disease
(b)

DUE TO, OR AS A CONSEQUENCE OF
Colon Cell Carcinoma
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
6 mos
3 yrs | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).
Chronic alcoholism | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET | | | CITY OR TOWN | COUNTY | STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19-18 19-82 to 11-23 19-82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | | | | 22b. DATE SIGNED
4/23/82 | | |
| 22c. SIGNATURE
Errol G. Phillips | | | DEGREE | | | ATTENDING
PHYSICIAN | | | MEDICAL
DIRECTOR <input type="checkbox"/> | STAFF
PHYSICIAN <input type="checkbox"/> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | | 23b. DATE
4-28-1982 | | | 23c. NAME OF CEMETERY OR CREMATORIAL
PINELAWN MEM. PARK | | | 23d. LOCATION
CITY OR TOWN
Annapolis, A.A. Maryland | | | | | |
| 24. FUNERAL DIRECTOR
NAME
WILLIAM REESE & SONS MORTUARY, P.A. | | | 25a. DATE REC'D. BY REGISTRAR
APR 29 1982 | | | 25b. REGISTRAR'S SIGNATURE
James J. Martin | | | | | | | | |

S C P 3-0 20

2000-2001

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8208453

REG. NO.

| | | | | | | | | | | | | | |
|---|------------------|---|--|---|---|--------------------------|--------------------------------------|--|----------------------------|--|--|--|--|
| 1- STATE REGISTRAR | | | | 2 DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR <input type="checkbox"/> 4 6 1982 | | | | | | | | | |
| 1. DECEDAE NAME FIRST MIDDLE LAST | | | | 2b. HOUR | | | | | | | | | |
| ADRIEN D. ROBERTS | | | | M | | | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD | MONTH DAY YEAR | 2d. HOUR | | | | | |
| Male | Black | 10 25 81 | YRS. 5 | MONTHS DAYS HOURS MIN. | | 4 6 1982 | 9:05 a.m. | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE MARYLAND | 13b. COUNTY A.A. | 13c. CITY OR TOWN ANAPOLIS | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1917 E. Copeland Street | | | | | | | | |
| 14. FATHER'S NAME FIRST RONALD MIDDLE MATTHEWS LAST | | 15. MOTHER'S MAIDEN NAME FIRST CYNTHIA MIDDLE ROBERT LAST | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT CYNTHIA ROBERT 1917 E. Copeland St. | | | ADDRESS Annapolis, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome
DUE TO, OR AS A CONSEQUENCE OF
7980
Conditions, if any, which
gave rise to immediate
cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Thomas D. Smith, M.D. Deputy Chief MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED 4-6-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | Thomas D. Smith, M.D. | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 4-9-1982 | | 23c. NAME OF CEMETERY OR CREMATORIAL PINELAWN MEM. PARK | | | 23d. LOCATION CITY OR TOWN Annapolis | | COUNTY A.A. STATE Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A. | | ADDRESS Annapolis, Md. | | | 25a. DATE REC'D. BY REGISTRAR APR 13 1982 | | | REGISTRAR'S SIGNATURE | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGES FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (5))
15M 2/80

80 28

1988

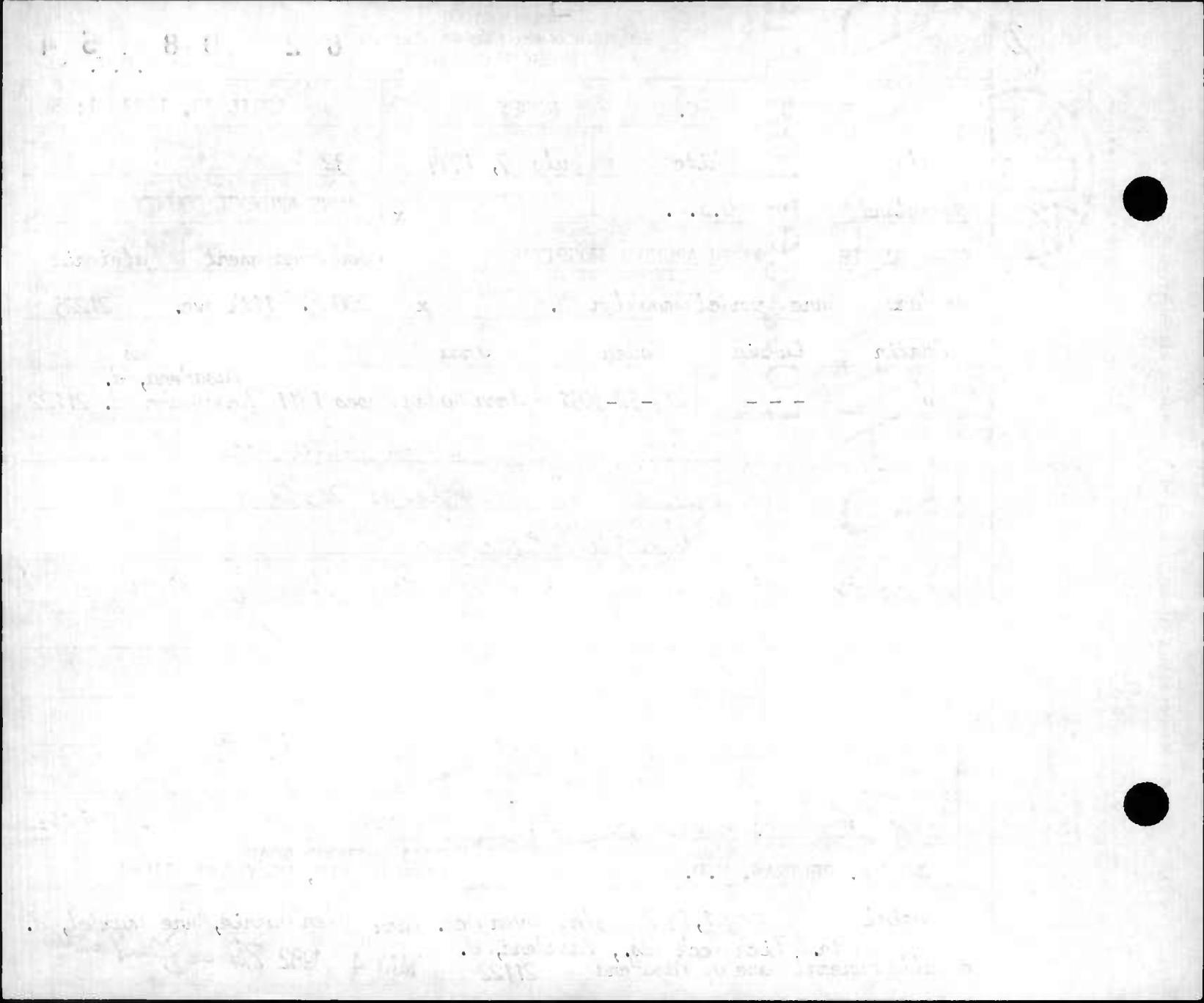
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | 8 2 0 8 4 5 4
E.D.T. | | | |
|---|--|------------------------------|--|---|--------|--|--|---|---|--|-----------------|---|--|---|--|
| 1 - FOR
STATE
REGISTRAR | | | | REG. NO. | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR
A
M | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | FIRST | MIDDLE | LAST | APRIL 29, 1982 | | | | 1:45 | | | | |
| EDWARD C. RODEY | | | | | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH
MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | |
| Male | | White | | July 7, 1949 | | | 32 YRS | | MONTHS DAYS | | HOURS MIN. | | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY
MD. | | | | | | | | |
| Maryland | | U.S.A. | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Food Management | | 12b. KIND OF BUSINESS OR
INDUSTRY
cafeteria | |
| GLEN BURNIE | | | | | | | | | | | | | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Brooklyn Pk. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
200 E. 11th Ave. 21225 | | | | | |
| 14. FATHER'S NAME
FIRST
Martin | | | | MIDDLE
Ludwig | | LAST
Rodey | | 15. MOTHER'S MAIDEN NAME
First
Irma | | Middle
Gus | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
217-52-3031 | | | | 17. INFORMANT
Irma Rodey Hypes, 1811 Chesapeake Rd. 21122 | | | | ADDRESS
Pasadena, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b and 1c)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)
250.3
Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause first:
Diabetic nephropathy
(c) DUE TO, OR AS A CONSEQUENCE OF
Hypertension | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I
Diabetic retinopathy, neuropathy; ulcers gastris | | | | | | | | | | | | | | | |
| 19. MEDICAL CERTIFICATION
DATE OF OPERATION | | | | 20. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
1st HOME, STREET, FACTORY, OFFICE, FARM, ETC. | | | | 21f. LOCATION
STREET | | CITY OR TOWN | COUNTY | SEAS | | | |
| 22a. I certify that (i) this hospital attended the deceased from 4/1/82 19 82 to 4/29 19 82, and that (ii) (we) did not view the body after death
now, the deceased alive on 4/29 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) did not view the body after death | | | | | | | | | | | | 22c. DATE SIGNED
4/29/82 | | | |
| 22b. SIGNATURE
Beltran MD. | | | | 22c. DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JUAN A. BELTRAN, M.D. | | | | 22e. ADDRESS
7951 OAKWOOD ROAD
GLEN BURNIE, MARYLAND 21061 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
May 1, 1982 | | 23c. NAME OF CEMETERY OR CREMATORIAL
Glen Haven Mem. Park | | | 23d. LOCATION
GLEN BURNIE, ANNE ARUNDEL, MD. | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
McCully Funeral Home of Pasadena | | | | 24a. DATE REC'D. BY REGISTRAR
MAY 4 1982 | | 24b. REGISTRAR'S SIGNATURE
James J. McCully | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR
MAY 4 1982 | | | | | | | | | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5. FOR YOUR FELLOWSHIP, MEDICAL EXAMINER'S PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. D 8 4 5 5 | | | |
|--|--|---------|--|------------------------------------|-------------------|---|---|---|---|--|-------------------------------|---|--------------------------------|--------------------------------------|--|
| 1. FOR
STATE
REGISTRAR | | | 2. DATE KNOWN
OF
ESTI-
DEATH
MATED | | | | | | | | | 2d. HOUR | | | |
| 11. DECEASED NAME
(TYPE OR PRINT) | | | MIDDLE | | | LAST | | | MONTH DAY YEAR | | | | | | |
| Paul | | | W. | | | Robinson | | | 8 4 17 1982 | | | A M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH
MONTH DAY YEAR | | | 6. AGE (IN YEARS
LAST BIRTHDAY)
48 yrs. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | 7c. DATE
PRONOUNCED
DEAD | | |
| M | | W | | March 27 34 | | | 48 yrs. | | | | | | 4 17 1982 A M | | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Va. | | | U.S.A. | | | | | | A.A.C.O. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | |
| Glen Burnie | | | North Arundel Hosp., Inc. | | | | | | | | | Truck Driver | | Freight | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS | | | MD. | |
| Md. | | | A.A. | | Glen Burnie | | | | | | 112 Range Rd. 21061 | | | | |
| 14. FATHER'S NAME
FIRST | | | MIDDLE | | | LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST | | | MIDDLE LAST | | | |
| Roscoe | | | | | | Robinson | | | Laura | | | Jean Yates | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | | | |
| no | | | 226-38-1223 | | | Gregory P. Robinson (same as 13e) | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coronary artery disease</i>
4149
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>last</i> | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION
STREET | | | CITY OR TOWN | | COUNTY | | STATE | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | TITLE (SPECIFY)
<i>Edmund J. L. L. M.D.</i> | | MEDICAL EXAMINER | |
| EXAMINER'S NAME
(TYPE OR PRINT) <i>F. L. L. M.D.</i> | | | | | | | | | | | | DATE SIGNED <i>4-7-82</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
4/20/82 | | | 23c. NAME OF CEMETERY OR CREMATORIUM
Cedar Hill Cemetery | | | 23d. LOCATION
CITY OR TOWN
Baltimore, Md. | | | COUNTY | | STATE | |
| 24. FUNERAL DIRECTOR
NAME
George J. Goncze F.H. | | | ADDRESS
4001 Ritchie Hwy. | | | 25a. DATE REC'D. BY REGISTRAR
APR 19 1982 | | | 25b. REGISTRAR'S SIGNATURE
<i>James Jan Harten</i> | | | | | | |

6.8

center civil labor

work on same site

adult male work position

(*) as many positions as possible

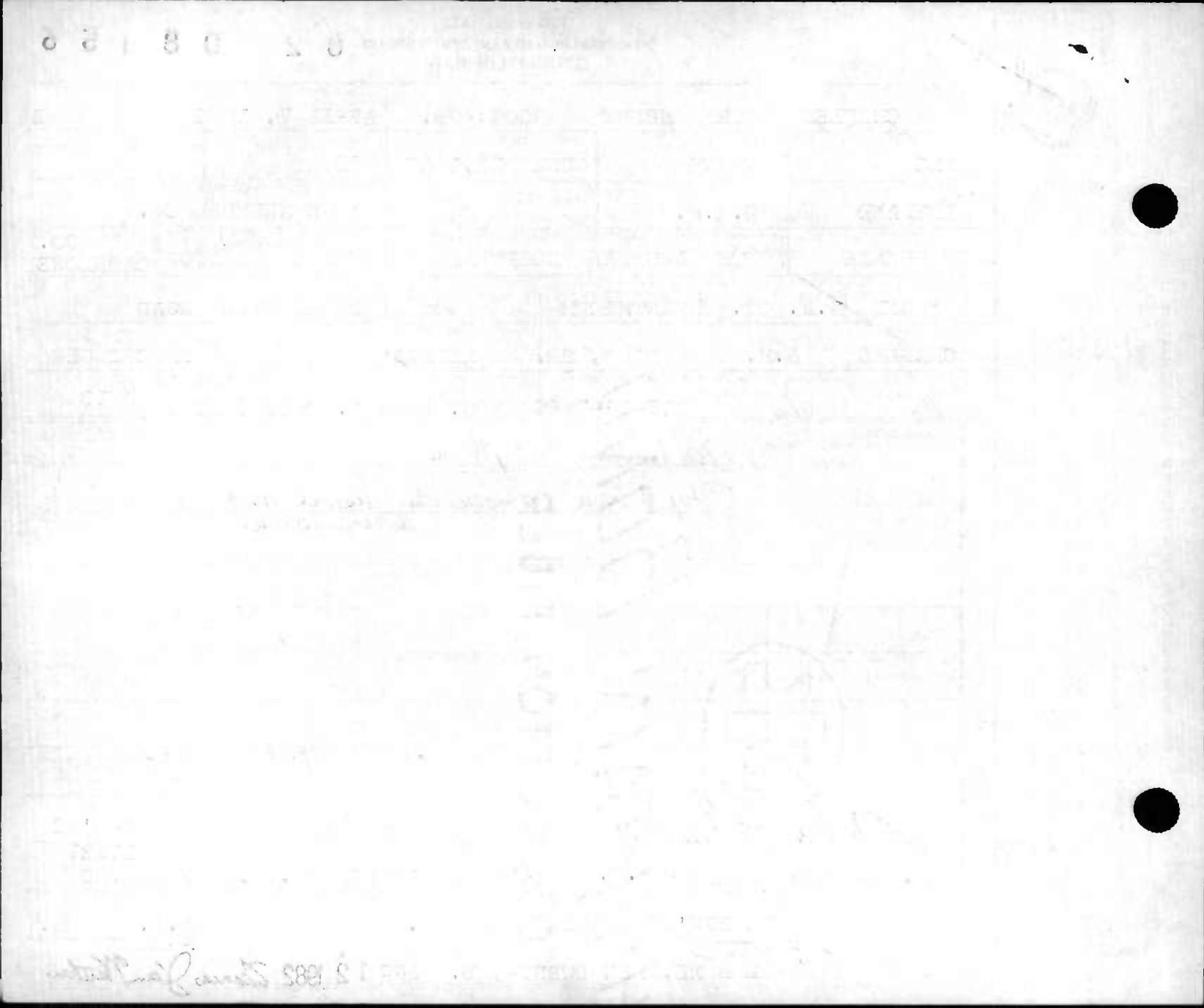
adult male work position

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of once with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 0 8 4 5 6 |
|--|--|---|---|--|--|-------------------------------|--|--|--|------------------------|
| 1. DECEASED NAME
FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR AM | | | | |
| CHARLES JOHN HENRY ROOS, JR. | | | APRIL 7, 1982 | | | | | | | |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH JUNE DAY 22, 1923 YEAR | 6. AGE (IN YEARS LAST BIRTHDAY)
58 | IF UNDER 1 YEAR
MONTHS YRS | | IF UNDER 24 HRS
HOURS MIN. | | | | |
| 7a. BIRTHPLACE STATE OR FOREIGN
COUNTRY
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL CO. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | 12a. USUAL OCCUPATION
(RETIRED) | | | 12b. KIND OF BUSINESS OR
TYPE OF WORK FOR MOST OF WORKING LIFE
INDUSTRY CO. MACHINE OPERATOR CARRLOWEY | | | | | |
| 13a. STATE
MARYLAND | 13b. COUNTY
A.A. CO. | 13c. CITY OR TOWN
LINTHICUM | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
29 HAMPTON ROAD | | | | | | |
| 14. FATHER'S NAME
FIRST
CHARLES | MIDDLE
J.H. | LAST
ROOS, SR. | 15. MOTHER'S MAIDEN NAME
FIRST
LILLIAN | MIDDLE
LAST
BLOCKINGER | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | 16b. SOCIAL SECURITY NO.
N/A | 16c. INFORMANT
217-12-7995 MRS. LELA J. ROOS (WIFE) | ADDRESS
Same as # 13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Zentricular Arrhythmia | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | |
| 4029
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last | | | DUE TO, OR AS A CONSEQUENCE OF
(b) Hypertensive cardiovascular disease and
atherosclerosis. | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET | CITY OR TOWN | COUNTY | STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 19 81 to April 19 82 , that (I) (we) lost
saw the deceased alive on 4-3 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (do not) did not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Barbara Cowley</i> | DEGREE | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> | MEDICAL DIRECTOR <input type="checkbox"/> | STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
9 APR '82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. BARBARA COWLEY, M.D. | 22e. ADDRESS
4000 ANNAPOLIS RD., BALTIMORE, MD | #1227 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
12 APR '82 | 23c. NAME OF CEMETERY OR CREMATORIAL
CEDAR HILL CEM. | 23d. LOCATION
CITY OR TOWN
BROOKLYN | COUNTY
A.A. | STATE
MD. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
SINGLETON FUNERAL HOME, GLEN BURNIE, MD. | ADDRESS
<i>J. Easter</i> | 25a. DATE REC'D. BY REGISTRAR
APR 12 1982 | 25b. REGISTRAR'S SIGNATURE
<i>Frances Jean Nathan</i> | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 16b g566 4/6/82 gj

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

 8 2 0 8 4 5 7
 0757
 MARCH 28 1982

REG. NO.

| | | | | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|-----------------|---|-------------------|--|
| 1. FOR
1 - STATE
REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 7b. HOUR | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | | MIDDLE | | LAST | | MARCH 28 1982 | | 0757 | |
| MANUEL J. Rosado | | | | | | | | | | | | |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 21 YEARS | |
| MALE | | | Hispanic | | MONTH DAY YEAR
Nov 30, 1902 | | 79 | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Puerto Rico | | | USA | | | | Anne Arundel Co. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Ft. Meade | | | Kimberrough Army Hosp. | | Retired Army | | Ret. | | | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS | | |
| MD | | | ANNARUNDEL | | ODenton | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 1628 Annapolis Rd. | | |
| 14. FATHER'S NAME | | | FIRST | | LAST | | 15. MOTHER'S MAIDEN NAME | | | ADDRESS | | |
| Ramon | | | Rosado | | Mercado | | Engrasria | | | 1628 Annapolis Rd. - ODenton MD | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| yes | | | 1931-61 | | Wife | | Myocardial Infarct | | | 40 min | | |
| | | | | | | | DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic Heart Disease | | | | | |
| | | | | | | | DUE TO, OR AS A CONSEQUENCE OF
(c) | | | 20 years | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).
<i>Dementia secondary to Normal Pressure Hydrocephalus</i> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____ | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from DEC 24 1981 to MAR 19 1982, that (I) (we) last saw the deceased alive on 24 Mar 1982, and that in (my) (we) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | 22b. SIGNATURE
<i>Joseph D. Zelig</i> M.D.
DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22c. DATE SIGNED
28 Mar 1982 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Joseph D. Zelig, CTC MC</i> | | | 22e. ADDRESS | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIAL | | 23d. LOCATION
CITY OR TOWN _____ COUNTY _____ STATE _____ | | | | | |
| Burial | | | March 31, 1982 | | Arlington National | | Arlington, Va. | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | | 25a. DATE REC'D. BY REGISTRAR
MAR 31 1982 | | | | | | | | | |
| Hardesty Funeral Home 12 Ridgeley Ave. Ann. Md. | | | 25b. SIGNATURE
<i>James J. Hardesty</i> | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

82 08458

REG. NO.

| | | | | | | | | | | | |
|---|--|---|---|-----------|---|--|--|-----------------------------------|-----------------|-----------------|------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | |
| <u>Henry L Rosendale</u> | | | | | | <u>04</u> | <u>17</u> | <u>82</u> | <u>3:30</u> | | |
| 3. SEX | | RACE | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| <u>Male</u> | | <u>White</u> | MONTH | DAY | YEAR | <u>65</u> | | MONTHS | DAYS | HOURS | MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | |
| <u>Md</u> | | <u>USA</u> | | | | <u>A A Co</u> | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT INUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| <u>ANNAPOLIS</u> | | <u>A-A GEN. HOSP</u> | | | <u>Clerk</u> | | | <u>Drug Co.</u> | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | | 14. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | |
| <u>Md</u> | | <u>AA</u> | <u>Crownsville</u> | | YES <input type="checkbox"/> | NO <input checked="" type="checkbox"/> | <u>393 LAUREL TR.</u> | | | | |
| 14. FATHER'S NAME | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | FIRST | MIDDLE | LAST | | |
| | | <u>LAWRENCE</u> | | <u>P.</u> | <u>HELEN D Rosendale</u> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <u>No</u> | | | 16b. SOCIAL SECURITY NO.
<u>213012551</u> | | | 17. INFORMANT
<u>HeLEN D. Rosendale - close</u> | | | ADDRESS | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) | | | DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Dysphagia associated with ---</u> | | | APPROXIMATE INTERVAL
BETWEEN IMMEDIATE AND DEATH
<u>3 days</u> | | | | | |
| 7104
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost. | | | DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Poly myositis</u> | | | | | | <u>3 months</u> | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.
<u>Undernutrition</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>N/A</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 21) | | | | | | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET | | CITY OR TOWN | | COUNTY | STATE | |
| 22a. I certify that (I) <u>the Hospital</u> attended the deceased from <u>Sept 4</u> 19 <u>73</u> to <u>April 17</u> 19 <u>82</u> that (I) <u>never</u> lost
saw the deceased alive on <u>April 17</u> 19 <u>82</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated
above, (I) <u>never</u> did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Charles W. Kinzer</u> | | 22c. DEGREE | | | ATTENDING
PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22d. DATE SIGNED
<u>19 Apr 1982</u> | | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>CHARLES W. KINZER MD</u> | | 22f. ADDRESS
<u>ANNAPOLIS, MARYLAND</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial 4/20/82</u> | | 23b. DATE
<u>Woodlawn</u> | | | 23c. NAME OF CEMETERY OR CREMATORIAL
<u>Woodlawn Cemetery</u> | | 23d. LOCATION
CITY OR TOWN
<u>Woodlawn Cemetery</u> | | COUNTY | STATE | |
| 24. FUNERAL DIRECTOR
<u>Paul J. Banano, Stevens Park</u> | | | | | 24b. DATE REC'D. BY REGISTRAR
<u>APR 22 1982</u> | | 24c. REGISTRAR'S SIGNATURE
<u>James J. Gaffney</u> | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8208459 | | | |
|--|--|---|--------|---|--------------------------|--|-----------------------------------|---|---------------------|---|-----------------|---------|------|
| | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a DATE OF DEATH | | | MONTH | DAY | YEAR | 2b HOUR | |
| CLEMENT | | | W. | ROSS | | APRIL 02 1982 | | | | | | 1350 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| MALE | | NEGRO | | MONTH | DAY | YEAR | 49 | | | MONTHS | DAYS | HOURS | MIN. |
| 10a. BIRTHPLACE
(STATE OR FOREIGN) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8c. MARRIED | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | | |
| MARYLAND | | U.S.A. | | <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
<input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | | ANNE ARUNDEL COUNTY | | | | | | | |
| 10c. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| FORT MEADE | | KIMBROUGH ARMY COMMUNITY HOSPITAL | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | | | |
| MARYLAND | | ANNE ARUNDEL | | ANNAPOLIS | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 735 BESTGATE ROAD | | | | |
| 14. FATHER'S NAME | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | | ADDRESS | | | | | |
| ROSS CHARLES | | | | NMI | PARKER ANNA B. | | | MOSANA ROSS 735 BESTGATE RD. ANNAPOLIS MD. | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | | ADDRESS | | | | | | |
| YES | | 216-36-5120 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC ABDOMINAL MALIGNANCY | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 MONTHS | | | |
| 19. CONDITIONS, IF ANY, WHICH
GOVE RISE TO IMMEDIATE
CAUSE (a), STATING THE
UNDERLYING CAUSE (b). | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| 20. CONDITIONS, IF ANY, WHICH
GOVE RISE TO IMMEDIATE
CAUSE (b), STATING THE
UNDERLYING CAUSE (c). | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2 APRIL 19 82 to 2 APRIL 19 82, that (I) (we) last
saw the deceased alive on 19 above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED
2 APRIL 82 | | | |
| 22b. SIGNATURE
<i>H. Saunders</i> | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HENRY SAUNDERS, CPT, MC | | 22e. DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
4-6-1982 | | 23c. NAME OF CEMETERY OR CREMATORIAL
FOWLER'S CHURCH CEMETERY | | 23d. LOCATION
CITY OR TOWN Annapolis COUNTY A.A. Maryland STATE | | | | | | | |
| 24. FUNERAL DIRECTOR
WILLIAM REESE & SONS MORTUARY, P.A. | | 25a. ADDRESS
Annapolis, Md. | | 25b. DATE REC'D. BY REGISTRAR
APR 6 1982 | | 25b. REGISTRAR'S SIGNATURE
<i>James J. Smith</i> | | | | | | | |

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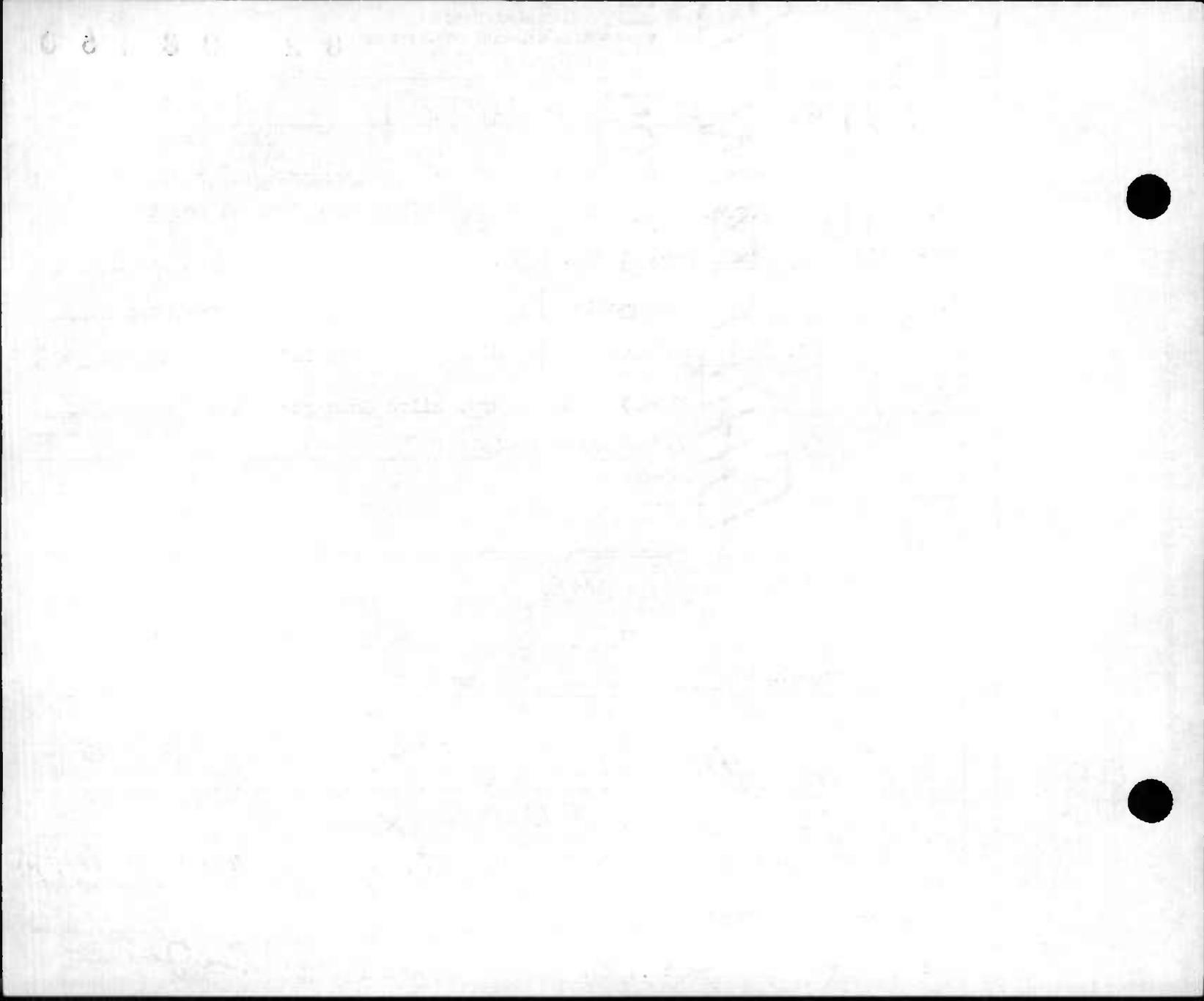
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certification must be completed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | 8208460 | REG. NO. | | |
|--|--|--|------------------|---|---------------------------------|---|--------------------------------|---|
| 1 - FOR STATE REGISTRAR | | 2a DATE OF DEATH | | MONTH | DAY | YEAR | 2b HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 49 82 | | 2:50 PM | |
| 3. SEX | | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS
HOURS MIN. |
| M | | W | MONTH | DAY | YEAR | 54 yrs. | | |
| 7a BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | |
| Md. | | U.S.A. | | | | Anne Arundel County MD. | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Annapolis | | Anne Arundel Gen. Hosp. | | N/A | | | | |
| 13a STATE
Md. | | 13b COUNTY
A.A. | | 13c. CITY OR TOWN
Annapolis | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
Bay Manor Nurs. Home |
| 14. FATHER'S NAME
FIRST
Leo | | MIDDLE
J. | LAST
Schwartz | 15. MOTHER'S MAIDEN NAME
FIRST
Hilma | | MIDDLE
Virginia | LAST
Sheldon | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO.
No 218-03-0168 | | 17. INFORMANT | | ADDRESS
Mrs. Hilma Schwartz Glen Burnie, Md. | | |
| PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)
4860 | | pneumonia | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost. | | (b) | | | | | | |
| (c) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.
Downs SYNDROME | | | | | | | | |
| 19a DATE OF OPERATION
none | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED
N/A | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
419 | | 21f. LOCATION
STREET
CITY OR TOWN
3116 419
19 82 19 82 | | COUNTY | STATE | |
| 22a. I certify that (I) this hospital attended the deceased from 4/9/82 to 4/19/82, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) we (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Thomas M Walsh MD | | DEGREE
ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
269 Peninsula Dr Farm Rd Annapolis MD | | | | |
| 22d. PHYSICIAN'S NAME
(TYPE OR PRINT)
THOMAS M. WALSH | | 22e. ADDRESS
269 Peninsula Dr Farm Rd Annapolis MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | 23b. DATE
4/12/82 | | 23c. NAME OF CEMETERY OR CREMATORIAL
Balto., Md. | | 23d. LOCATION
CITY OR TOWN
COUNTY
STATE | | |
| 24. FUNERAL DIRECTOR
NAME
Anatomy Board | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
APR 15 1982 | | 25b. REGISTRAR'S SIGNATURE
Anne Jean Parchen | | |

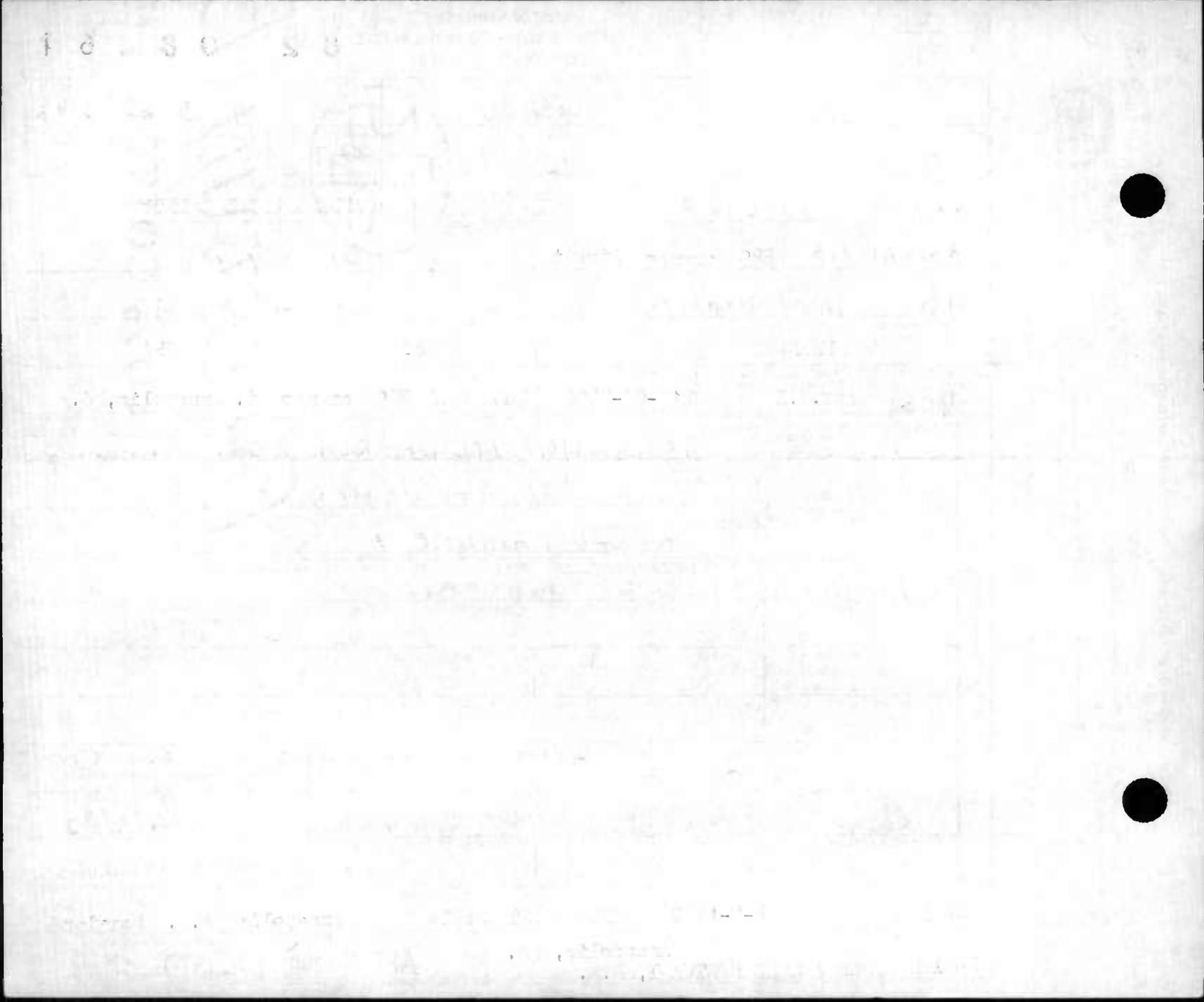


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 8 4 6 1 | REG. NO. | | | |
|---|--|--|---|--|--|--|--|--|--|---|----------|---|--|--|
| 1- STATE REGISTRAR | | | | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | | | | |
| JAMES | | | SHAW | | | 4 3 82 | | | 2-45 PM | | | | | |
| 3. SEX M | | | 4. RACE N | | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 18 94 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
YRS. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) TEXAS | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH ANNAPOLIS | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
889 Marengo Street | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
UNEMPLOYED | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE ND. | | | 13b. COUNTY ANNE ARUNDEL | | | 13c. CITY OR TOWN ANNAPOLIS | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
889 MARENGO ST. | | |
| 14. FATHER'S NAME
FIRST UNKN OWN MIDDLE LAST | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST ELSIE MIDDLE LAST SHAW | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | | 16b. SOCIAL SECURITY NO.
W.W.I | | | 17. INFORMANT
ADDRESS
ELLA SHAW 889 Marengo St. Annapolis, Md. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 months | | | | |
| 5860
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last. | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF
C.H.F., SENILE DEMENTIA | | | | | | | | | | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF
RENAL FAILURE. | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
ADENOCARCINOMA PROSTATE | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/19/82 to 4/3/82, that (I) (we) lost
saw the deceased alive on 4/2/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED
4/3/82 | | | | |
| 22b. SIGNATURE
RANI S. KARIPINENI | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RANI S. KARIPINENI | | | 22e. DEGREE
M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | | 23b. DATE
4-7-1982 | | | 23c. NAME OF CEMETERY OR CREMATORIAL
HILL CREST CEMETERY | | | 23d. LOCATION
CITY OR TOWN Annapolis
COUNTY A.A. Maryland
STATE | | | | | |
| 24. FUNERAL DIRECTOR
NAME WILLIAM REESE & SONS MORTUARY, P.A. | | | | | | 25a. DATE REC'D. BY REGISTRAR
APR 6 1982 | | | 25b. REGISTRAR'S SIGNATURE
Anne Jan Norton | | | | | |
| BP | | | | | | | | | | | | | | |
| DHMH - 16 50M 1/B1
(VRA 15, 4) | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please remove carbon paper. Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | 8 2 0 8 4 6 2
EST | | | |
|---|--|--|---|--------|------|--|--|--|--|-----|----------|---|-------|-------------------|----------------|
| 1 - FOR
STATE
REGISTRAR | | | | | | | | | | | REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a DATE OF DEATH | | | MONTH | DAY | YEAR | 2b HOUR | | | |
| CLYDE H. SLONAKER | | | | | | APRIL 12, 1982 | | | | | | 12 noon | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Male | | | White | | | July 15 1896 | | | 85 | | | MONTHS | YEARS | HOURS | MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 | | | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | | USA | | | | | | | | | ANNE ARUNDEL COUNTY MD. | | | |
| 10 CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | |
| GLEN BURNIE | | | NORTH ARUNDEL HOSPITAL | | | Carpenter | | | Construction | | | | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Anne Arundel | | | 13c. CITY OR TOWN
Pasadena | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS
202 Magothy Bridge Rd. 21122 | | | |
| 14. FATHER'S NAME
FIRST
John | | | MIDDLE
L. | | | LAST
Slonaker | | | 15. MOTHER'S MAIDEN NAME
FIRST
Mary | | | MIDDLE
Ellen | | | LAST
Mitten |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | | 17. INFORMANT | | | ADDRESS | | | | | | |
| No | | | -- | | | 218-09-1896 | | | Ida F. Slonaker | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) <i>Cardio respiratory arrest</i> | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| 4960
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last:
(b) <i>Lt lower lobe pneumonia</i>
(c) <i>Severe COPD</i> | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE
AT WORK <input type="checkbox"/> NOT WHILE
AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.) | | | 21f. LOCATION
STREET | | | CITY OR TOWN | | COUNTY | | STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | 22c. DATE SIGNED
4/12/82 | | | |
| 22b. SIGNATURE
<i>Basant K. Khanelwal</i> | | | 22c. DEGREE
MEDICAL | | | ATTENDING
PHYSICIAN <input type="checkbox"/> MEDICAL
DIRECTOR <input type="checkbox"/> STAFF
PHYSICIAN <input type="checkbox"/> | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BASANT K. KHANELWAL, M.D. | | | 22e. ADDRESS
205 BALTIMORE-ANNAPOLIS BLVD.
GLEN BURNIE, MARYLAND 21061 | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
4/16/82 | | | 23c. NAME OF CEMETERY OR CREMATORIAL
Lorraine Park Cem. | | | 23d. LOCATION
CITY OR TOWN
Baltimore | | | COUNTY | | STATE
Maryland | |
| 24. FUNERAL DIRECTOR
NAME
A. Alan Seitz Funeral Home | | | ADDRESS
3818 Roland Ave. | | | 25a. DATE REC'D. BY REGISTRAR
APR 19 1982 | | | 25b. REGISTRAR'S SIGNATURE
<i>James O. Martin</i> | | | | | | |

20.80.8

1

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY OCCURS, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|-------------------------------------|-----|---|-----------|--------------------------------------|--|
| 1- STATE
REGISTRAR | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 0 2 | 0 8 4 6 3 | | |
| | | | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a DATE KNOWN
OF ESTI-
DEATH MATED | | MONTH | DAY | YEAR | 2b. HOUR | | |
| Joseph | | T. | | Smallwood | | | | <input checked="" type="checkbox"/> | | 4 | 4 | 1982 | M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS
LAST BIRTHDAY)
YRS. | | IF UNDER 1 YR.
MONTHS | | IF UNDER 24 HRS.
DAYS HOURS MIN. | | 2c. DATE
PRONOUNCED
DEAD | | 2d. HOUR
3:09
P.M. | |
| Male | | White | | Jan. 25, 1925 | | 57 | | | | | | 4 4 1982 | | | |
| 7a BIRTHPLACE
(STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED
<input checked="" type="checkbox"/> NEVER MARRIED
<input type="checkbox"/>
WIDOWED | | 9. MARRIED
<input checked="" type="checkbox"/> NEVER MARRIED
<input type="checkbox"/>
DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County, MD. | | | | | | | |
| Maryland | | U.S.A. | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | |
| Glen Burnie | | North Arundel Hospital | | | | | | | | | | Plant operator | | Chemical | |
| 13a. STATE
Md. | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
1012 Big Baer Dr. 21061 | | Baer | | | | | |
| 14. FATHER'S NAME
First Louis | | Middle | | Last Smallwood | | 15. MOTHER'S MAIDEN NAME
First Agnes | | Middle | | Last Shaughter | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
218-14-7478 | | 17. INFORMANT
Smallwood | | ADDRESS
Betty J. Adecock (same as 13e) | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| 4292
Conditions, if any, which
gave rise to immediate
cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o). | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | Virginia L. Dolan | | | | | | | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | Virginia L. Dolan, M.D. | | | | | | | | | | ADDRESS
111 Penn Street | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIES) | | 23b. DATE
Burial 4/7/82 | | 23c. NAME OF CEMETERY OR CREMATORIAL
Meadowridge Memorial Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN
Baltimore, Md. 21225 | | COUNTY | | 21227 STATE | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | 21225 | | 25a. DATE REC'D. BY REGISTRAR
George J. Gonc F.H. 4001 Ritchie Hwy. | | 25b. REGISTRAR'S SIGNATURE | | APR 8 1982 | | Z. J. O'NEIL | | | | | |
| DHMH - 17
(VRA15 ME (5))
15M 2/80 | | | | | | | | | | | | | | | |

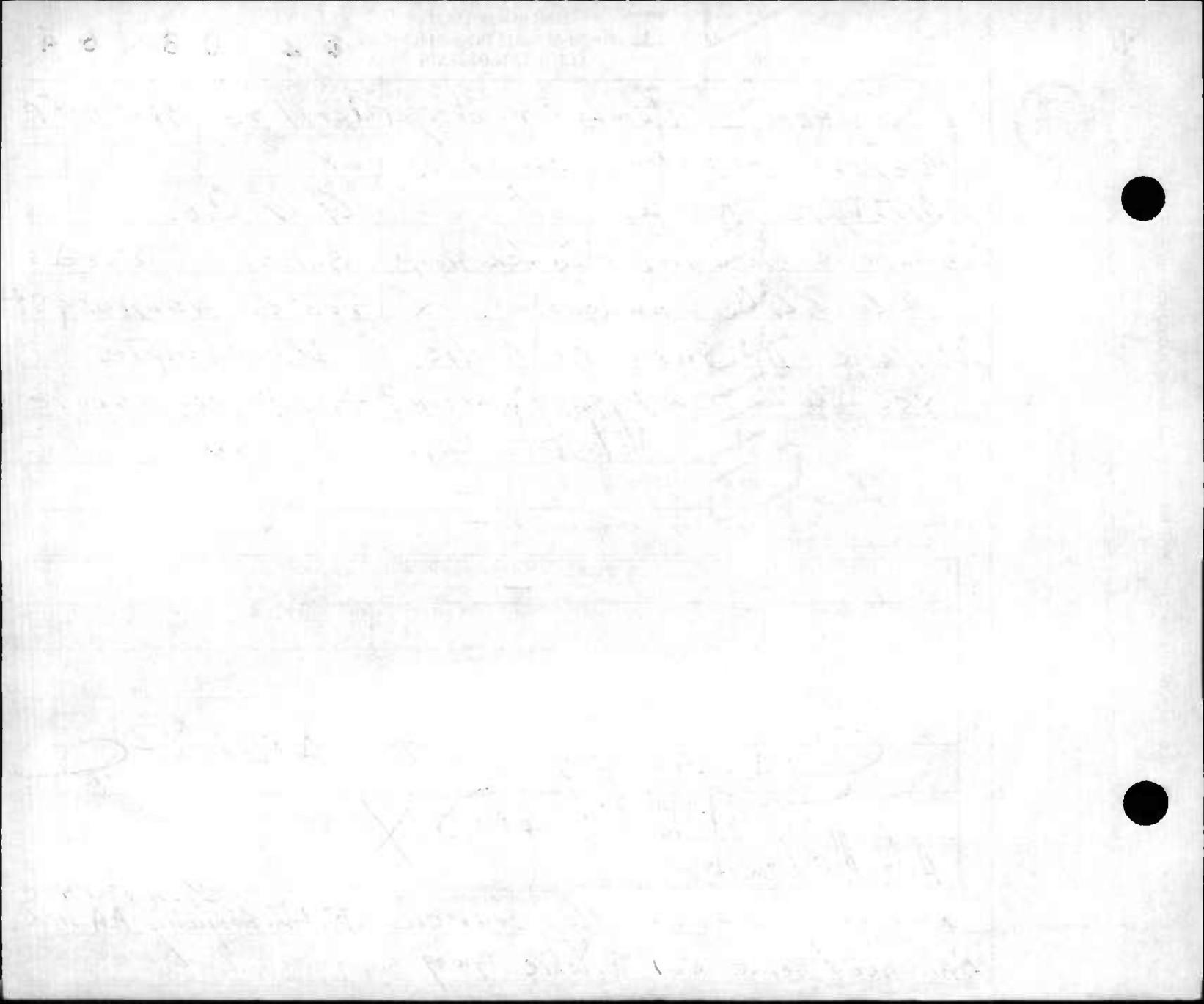
2013-2014

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | 8208464 | | | | |
|--|--|--|---|--------|------|---|--|--|---|-----------|-------------|---|--|-------------------------------|--|--|
| | | | | | | | | | | | | REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | | | | |
| <i>Daniel Thomas Snowberger</i> | | | | | | <i>April 23 1982</i> | | | <i>APR</i> | <i>23</i> | <i>1982</i> | <i>11:15 PM</i> | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| <i>Male</i> | | | <i>white</i> | | | <i>12 24 17</i> | | | <i>64</i> | | | <i>YRS.</i> | | <i>MONTHS DAYS HOURS MIN.</i> | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | | |
| <i>Baltimore</i> | | | <i>U.S.A.</i> | | | | | | <i>G.G.C.O.</i> | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | |
| <i>Carnapolis</i> | | | <i>Gene Grande Co. Gen. Hosp</i> | | | <i>Sales.</i> | | | <i>Ward 5.</i> | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS | | | | |
| <i>Md</i> | | | <i>Glendale</i> | | | <i>Pasadena</i> | | | | | | <i>105 W. Hampstead</i> | | | | |
| 14. FATHER'S NAME
FIRST | | | MIDDLE | | | LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST | | | MIDDLE | | | | |
| <i>Willard</i> | | | <i>D.</i> | | | <i>Snowberger</i> | | | <i>Nettie</i> | | | <i>McCompte</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO OR UNKNOWN | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | | | | |
| <i>yes</i> | | | <i>WW II 217-97194</i> | | | <i>Marian Snowberger, as above</i> | | | | | | | | | | |
| II. CAUSE OF DEATH: Enter only one cause per line for item 18a. (a) PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | |
| <i>1509</i>
Condition, if any, which
gave rise to immediate
cause (a), stating the
underlying cause first
(b) | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. | | | | | | | | | | | | | | | | |
| 18a. DATE OF OPERATION | | | 18b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 18c. AUTOPSY? | | | 18d. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 18e. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
<input type="checkbox"/> IF EITHER, NOTIFY MEDICAL EXAMINER | | | 18f. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 18g. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18c, PART I OR PART II) | | | | | | | | | | |
| 18h. INJURY OCCURRED | | | 18i. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 18j. LOCATION
STREET | | | CITY OR TOWN | | | COUNTY | | STATE | | |
| 18k. I certify that (i) this physician attended the deceased from <i>1978</i> to <i>1982</i> and saw the deceased alive on <i>1982</i> and that (ii) my (our) opinion death occurred on the date and hour and from the cause(s) stated above. (If two, did not) view the body after death. | | | | | | 19. TO 19 <i>1982</i> to <i>4-23 1982</i> shot (i) (we) last | | | | | | | | | | |
| 18l. SIGNATURE | | | 18m. DEGREE | | | 18n. ATTENDING
PHYSICIAN <input checked="" type="checkbox"/> MEDICAL
DIRECTOR <input type="checkbox"/> STAFF
PHYSICIAN <input type="checkbox"/> | | | 18o. DATE SIGNED | | | | | | | |
| 18p. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 18q. ADDRESS | | | | | | | | | | | | | |
| <i>A.G. Alexander</i> | | | | | | | | | | | | | | | | |
| 18r. BURIAL, CREMATION, REMOVAL
SPECIAL | | | 18s. DATE | | | 18t. NAME OF CEMETERY OR CREMATORIUM | | | 18u. LOCATION
CITY OR TOWN | | | COUNTY | | STATE | | |
| <i>Burial</i> | | | <i>4-26-82</i> | | | <i>Hanover</i> | | | <i>Richie Hwy</i> | | | <i>Hen. Bonnie</i> | | | | |
| 18v. FUNERAL DIRECTOR
NAME | | | 18w. ADDRESS | | | 18x. DATE REC'D. BY REGISTRAR | | | 18y. REGISTRAR'S SIGNATURE | | | | | | | |
| <i>Barranco & Home 501 Richie Hwy</i> | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after it is retained by the hospital or attending physician.

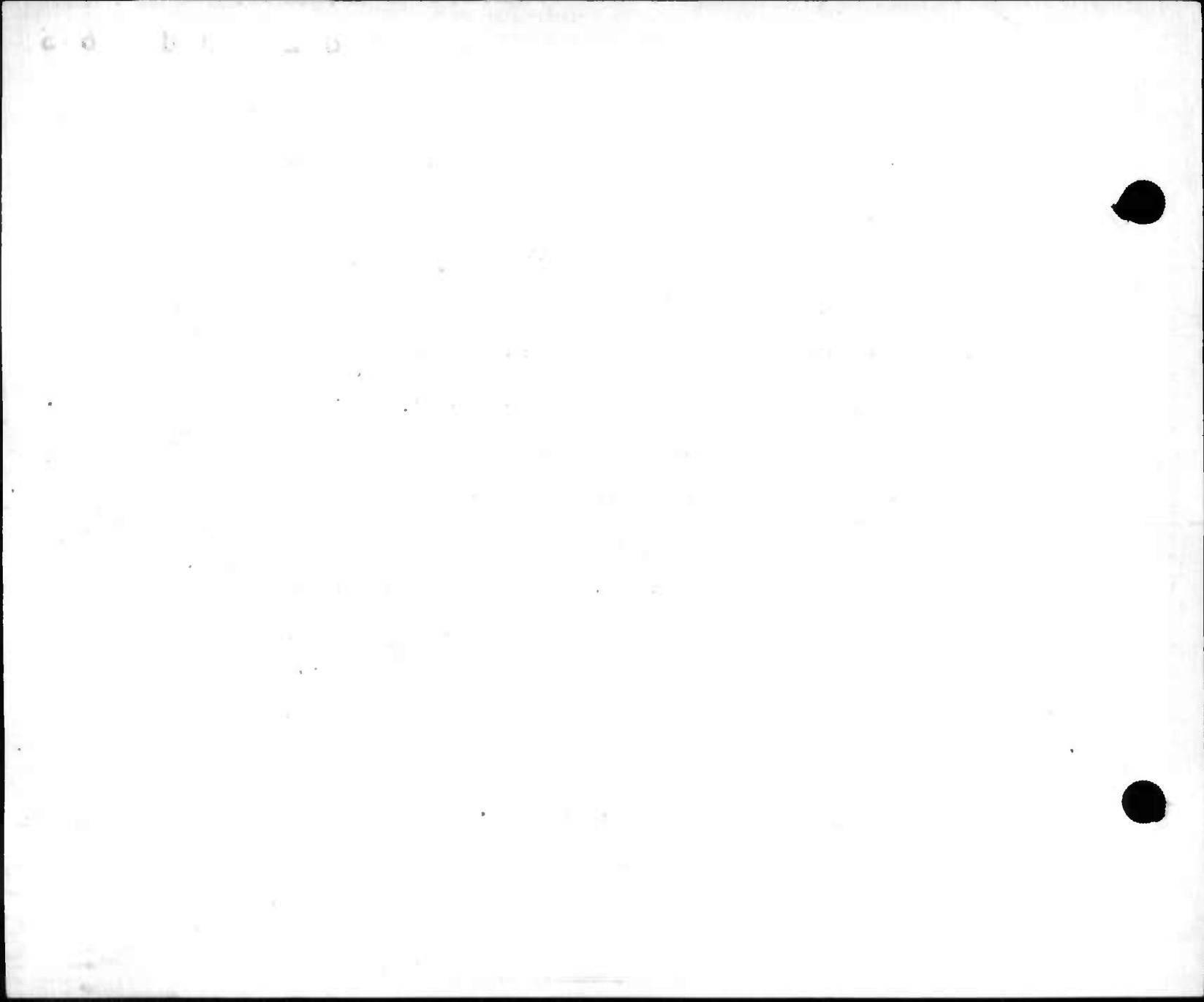
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 4 of 4

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8208465 | | |
|--|--------|---|-------------------|--------------------------------------|--|---|--|---------------------|---|------------------------------------|-----------------------------------|---|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | | |
| MARGARET Jayne STAFFORD | | | | | | 04 | 04 | 82 | | 9 ¹⁸ PM | | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | | | | |
| FEMALE | White | MONTH | DAY | YEAR | YRS. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Holidaysburg, Pa | | USA | | | | | | | Anne Arundel Co. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| ANNAPOLIS | | ANNE ARUNDEL GENERAL Hospital | | | housewife | | | | | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | | | |
| Md | | AA | Galesville | | | | | 4824 Riverside Dr. | | | | |
| 14. FATHER'S NAME | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Martin Edgar Feathers | | | | | Mary | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | ADDRESS | | | | | |
| NO | | 150 09 5356 | | | Judd Stafford, Galesville, Md | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest | | | | | | | | | | | | 20 min. |
| 4280
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last | | | | | | | | | | | | |
| (b) Acute Renal Insufficiency | | | | | | | | | | | | 24 hrs |
| { DUE TO, OR AS A CONSEQUENCE OF
(c) Congestive Heart Failure | | | | | | | | | | | | 24 hrs |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| Diabetes, Cirrhosis of the Liver, Possible Gram Negative Sepsis | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | | | | | |
| none | | | | | <input type="checkbox"/> YES <input type="checkbox"/> | | <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | <input type="checkbox"/> YES <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED

WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET | | CITY OR TOWN | | COUNTY | STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 19 81 to Present 19 , that (I) (we) last
saw the deceased alive on this day April 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | 22c. ATTENDING
PHYSICIAN | | MEDICAL
DIRECTOR | | STAFF | PHYSICIAN <input type="checkbox"/> | DATE SIGNED | |
| William B. Freedberg | | | | | <input checked="" type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | April 4, 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | WEST River | | | | | | | |
| William B. Freedberg M.D. | | 134 Owingsville Road, MD 20778 | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION
CITY OR TOWN | | COUNTY | STATE | | |
| Cremation | | 4-8-82 | | Cedar Hill | | | Suitland PG Co Md | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| T.A. Hardesty | | Annapolis Maryland 21401 | | | APR 6 1982 | | Anne J. Hardesty | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8 2 0 8 4 6 6
REG. NO.

1- STATE
REGISTRAR

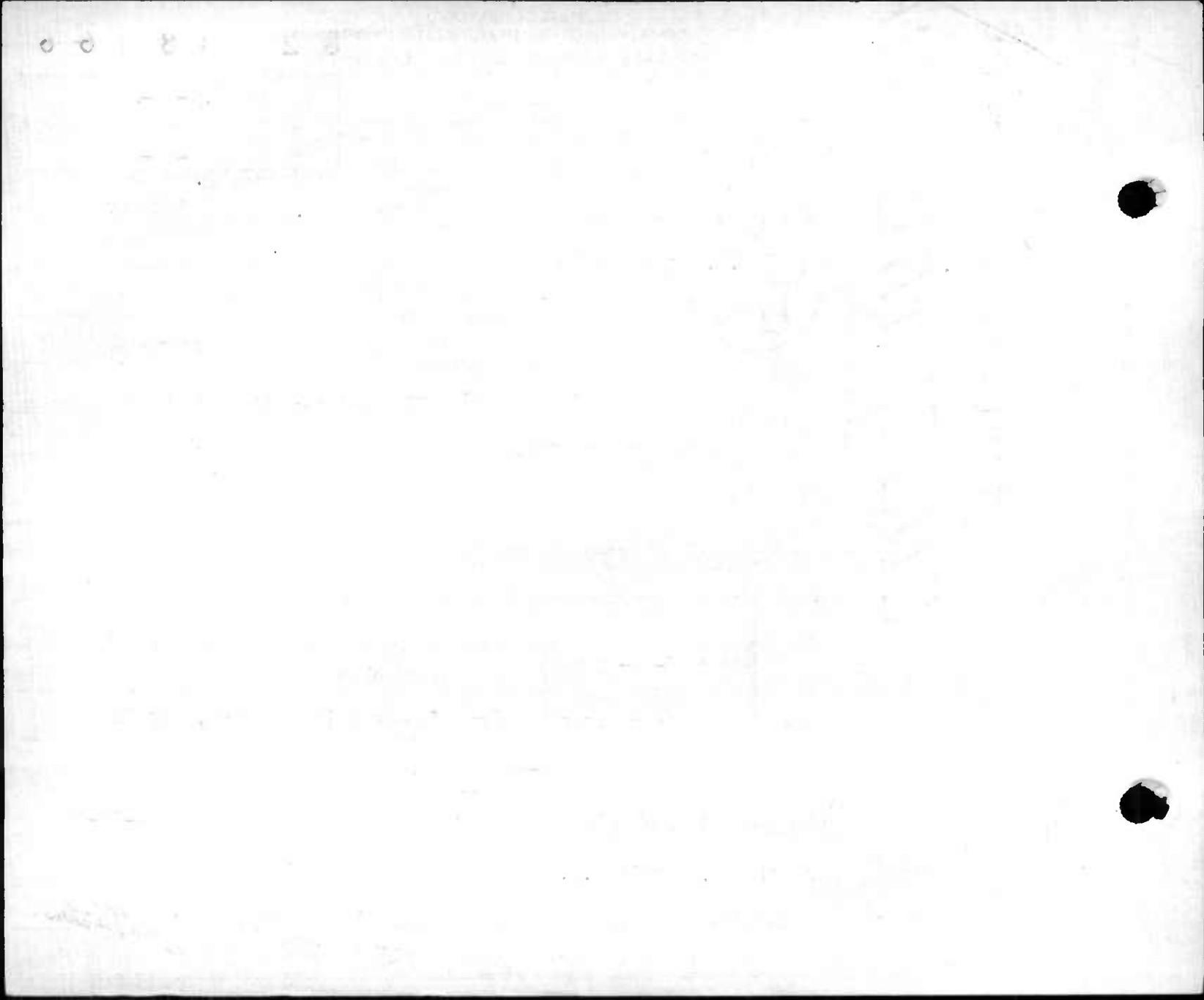
| | | | | | | | | | | | |
|---|---------|--|--|--|--|---|--|---------|--------------------------------------|---|-----------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | | | 2a. DATE KNOWN
OF DEATH
ESTIMATED | MONTH | DAY | YEAR | 2b. HOUR |
| (RONALD) RONNIE STARR | | | | | | | <input checked="" type="checkbox"/> | 4-28-82 | 19 | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | 6. AGE (IN YEARS)
LAST BIRTHDAY
YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN | | 2c. DATE
PRONOUNCED
DEAD | MONTH | DAY | YEAR | 4:15 P.M. |
| male | black | 5 18 56 | 25 | | | | 4-28-82 | 19 | | | |
| 7a. BIRTHPLACE
(STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| MD | | USA | | | | | Anne Arundel County MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | |
| Ft. Meade | | U.S. Army Hospital | | | | | | | | | |
| 13a. STATE
MD | | 13b. COUNTY | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
770 W. Saratoga St. | | | | |
| 14. FATHER'S NAME
Rober | | MIDDLE Starr LAST | | | 15. MOTHER'S MAIDEN NAME
Almenta | | | | LAST Bennett | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
N/A | | | 17. INFORMANT
Almeta Bennett | | ADDRESS
3503 Fairview Avenue | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) <u>Stabwound of chest</u>
DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the underlying cause last.

(b)
DUE TO, OR AS A CONSEQUENCE OF

(c) | | | | | | | | | | | |
| APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
3 PM 4-28-82 YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
subject stabbed | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)
dormitory area | | | 21f. LOCATION
STREET House of Correction CITY OR TOWN Jessup, Maryland STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion
death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL
SIGNATURE
<i>Margie Anne Kornell</i> | | TITLE (SPECIFY)
M.D. Assistant | | | | | MEDICAL EXAMINER | | | | |
| DATE SIGNED 4-29-82 | | | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS 111 Penn Street | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE
Burial 5/3/82 | | 23c. NAME OF CEMETERY OR CREMATORIAL
King Memorial Park | | | 23d. LOCATION
CITY OR TOWN Baltimore | | COUNTY STATE
So. Queen | | |
| 24. FUNERAL DIRECTOR
NAME Wm. C. March F/H ADDRESS 1101 E. North Ave. | | | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR APR 30 1982
25b. REGISTRATION SIGNATURE <i>James</i> | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 8 4 6 7
EST | | | |
|---|--|---|-------|---|------|---|--------------------------------------|---------------------|-----------------|----------------------|-----------------|---|--|
| | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2d. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | |
| CHARLES FLOYD STEWART Sr. | | | | | | APRIL 12, 1982 | | | | | | 1:00 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| Male | | White | | Dec. 27 1919 | | 62 | | | YEARS | MONTHS | DAYS | HOURS | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | | |
| Tennessee | | U.S.A. | | | | ANNE ARUNDEL COUNTY | | | L.H.Cranston | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | |
| GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | | Plumber | | | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Linthicum | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | | | | |
| | | | | | | | | 514 Cheddington Rd. | | | | | |
| 14. FATHER'S NAME
FIRST | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME
FIRST | | MIDDLE | | LAST | | | |
| Charles | | | | Stewart | | Mary | | | | Botwright | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR & DATES) | | 17. INFORMANT | | ADDRESS | | | | | | | |
| yes | | W.W.II | | 413-10-5026 | | Dorothy M. Stewart (same as 13e) | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Shock</i> | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| 5715
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) <i>Adult Respiratory Distress Syndrome</i> | | | | | | | | | | | | | |
| { DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Pulmonary Hemorrhage</i> | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1
<i>Cirrhosis of Liver, End Stage congestive heart failure, Renal Failure</i> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET | | CITY OR TOWN | | COUNTY | | STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from
saw the deceased live on <i>4/12/82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) did (did not) view the body after death. | | | | 19 80 | | to 9/12 1982 | | | | | | | |
| 22b. SIGNATURE
<i>Glenn F. Robbins</i> | | DEGREE
<i>MD</i> | | ATTENDING
PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | MEDICAL
STAFF | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GLENN F. ROBBINS, M.D. | | 22e. ADDRESS
1404 CRAIN HIGHWAY, S., #300
GLEN BURNIE, MARYLAND 21061 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Entombment | | 23b. DATE
4/15/82 | | 23c. NAME OF CEMETERY OR CREMATORIAL
Glen Haven Memorial | | 23d. LOCATION
CITY OR TOWN
Baltimore | | COUNTY | | STATE
Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
George J. Gonce F.H. | | ADDRESS
4001 Ritchie Hwy. | | 25a. DATE REC'D. BY REGISTRAR
REGISTRAR'S SIGNATURE
Frances Jean Hartman | | 25b. DATE REC'D. BY REGISTRAR
REGISTRAR'S SIGNATURE | | | | | | | |
| | | | | APR 19 1982 | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

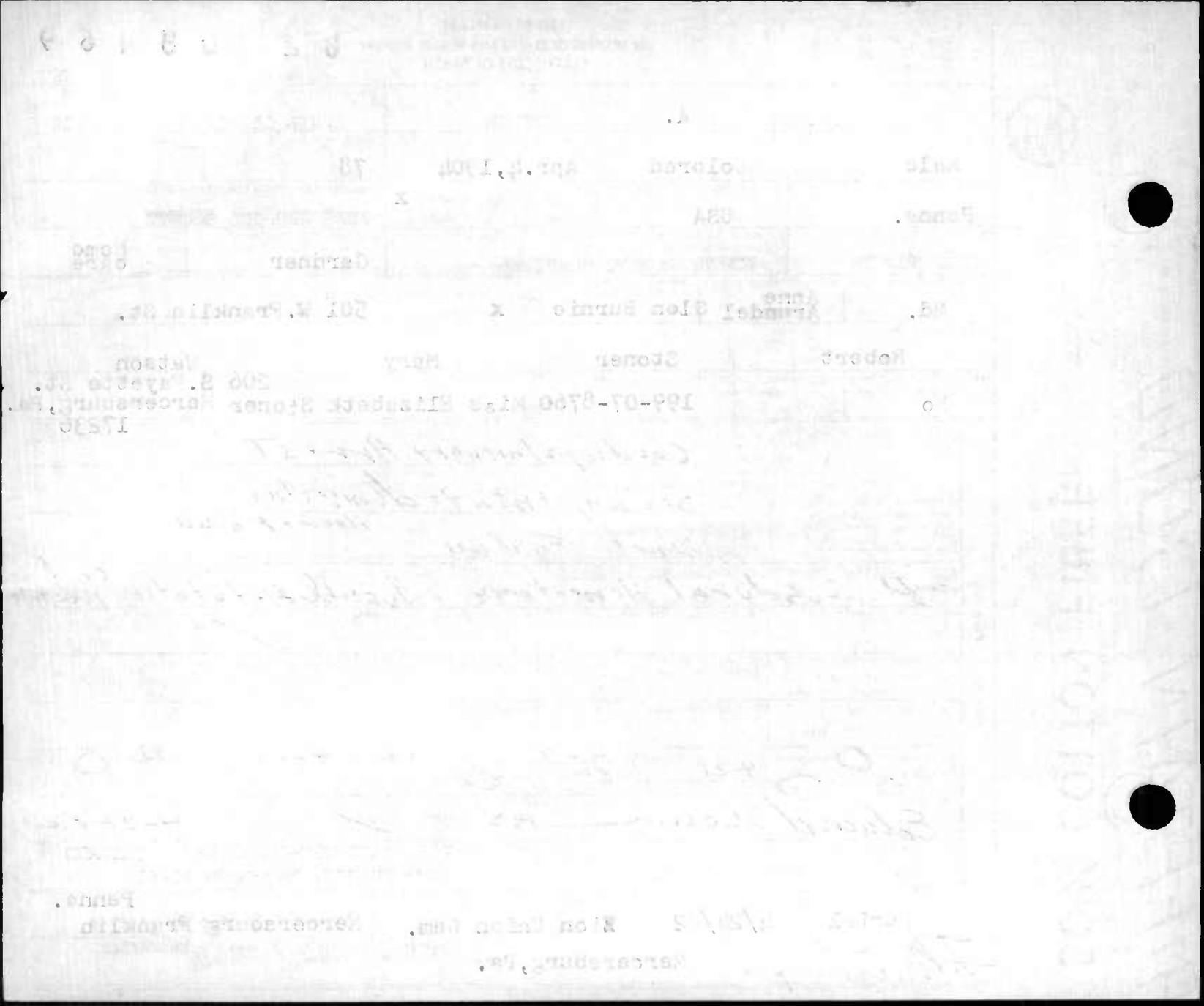
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | 8 2 0 8 4 6 8 | | | |
|---|--|--|---|---|--|--|-------------------------------------|--|---|-----------------|--------------|--|--|-----------------------------------|--|
| | | | | | | | | | | | | REG. NO. | | | |
| 1 - FOR STATE REGISTRAR | | | FIRST | | | MIDDLE | | | LAST | | | 2a DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | JOSEPH | | | DAVIE | | | STINCHCOMB | | | April 17, 1982 | | 11:40A M | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| Male | | White | | June 10, 1917 | | | 64 | | | MONTHS | | DAYS | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | | | |
| Maryland | | U.S.A. | | MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | Anne Arundel | | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(NOT IN HOSPITAL FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Glen Burnie | | 111 Main Avenue S.E. | | | | | | | | | | Supervisor | | Meat | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | 13a. STATE | | | |
| | | | | | | | | | | | | 13b. COUNTY | | | |
| | | | | | | | | | | | | 13c. CITY OR TOWN | | | |
| | | | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| | | | | | | | | | | | | 13e. STREET ADDRESS | | | |
| | | | | | | | | | | | | 131 Main Avenue | | | |
| 14. FATHER'S NAME | | | FIRST | | | MIDDLE | | | LAST | | | 15. MOTHER'S MAIDEN NAME | | | |
| Joseph | | | Davie | | | Stinchcomb | | | Mary | | | = Cermak | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | | | |
| No. | | | 215-09-9587 | | | Joseph Stinchcomb (Prearranged) | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for item 18, Part 1.)
PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) <i>Metastatic carcinoma of the prostate 6 mo.</i> | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) _____ | | | | | | | | | | | | | | | |
| Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause (last).
(c) _____ | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>None</i> | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| | | | | | | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> | | | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
F.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FAIR, ETC.) | | | 21f. LOCATION
STREET | | | CITY OR TOWN | | COUNTY STATE | | | | |
| 22a. I certify that (I) (he) hospitalized the deceased from <i>June 10, 1950</i> to <i>April 17, 1982</i> , to <i>April 19, 1982</i> , that (I) (we) last saw the deceased alive on <i>April 6, 1982</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I did) (I did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | IN DATE SIGNED | | | | | | |
| R. M. McLaughlin, M.D. | | | | | | | | | 4/17/82 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | | | | | |
| R. M. McLaughlin M.D. | | | 3708 Mountain Rd. Pasadena, Md. | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIUM | | | 23d. LOCATION
CITY OR TOWN | | | STATE | | | |
| Burial | | | 4/21/82 | | | Davis Cemetery | | | Davis | | | Tucker, W. Va. | | | |
| 24. FUNERAL DIRECTOR
NAME | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| Raymond C. Fink | | | Glen Burnie, Md. | | | APR 19 1982 | | | Anne Arundel | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 8208469
EST | |
|--|--|---|---|-----------|---|---|--|--|---|-----|------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MAURICE | MIDDLE A. | LAST STONER | 2a. DATE OF DEATH APRIL 21, 1982 | | | MONTH | DAY | YEAR | 2b. HOUR 4:20 P | |
| 3 SEX Male | | | 4 RACE Colored | | | 5. DATE OF BIRTH MONTH DAY YEAR
Apr. 4, 1904 | | | 6 AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS
HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna. | | | 7b CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL | | | 12a. USUAL OCCUPATION Gardner | | | 12b. KIND OF BUSINESS OR INDUSTRY home care | | | | |
| 13a. STATE Md. | | | 13c. CITY OR TOWN Anne Arundel Glen Burnie | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 501 W. Franklin St. | | | | |
| 14. FATHER'S NAME FIRST Robert MIDDLE Stoner LAST | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Watson LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 199-07-8760 | | | 17. INFORMANT ADDRESS 206 S. Fayette St.
Miss Elizabeth Stoner Mercersburg, Pa. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 5860 | | | DUE TO, OR AS A CONSEQUENCE OF (b) decompen.sated congestive Heart Failure | | | DUE TO, OR AS A CONSEQUENCE OF (c) renal Failure | | | APPROXIMATE NUMBER OF DAYS BETWEEN ONSET AND DEATH 172 | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a
right Subdural Hematoma Possible Metastatic prostate | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 4-9, 1982, to 4-21, 1982, that (1) we last saw the deceased alive on 4-21, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) we (did) did not view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Edward Sherman | | DEGREE M.D. | | | 22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | DATE SIGNED 4-21-82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD N. SHERMAN, M.D. | | 22e. ADDRESS 205 BALTIMORE-ANNAPOLIS BOULEVARD
GLEN BURNIE, MARYLAND 21061 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 4/24/82 | | | 23c. NAME OF CEMETERY OR CREMATORIALION Union Cem. | | | 23d. LOCATION CITY OR TOWN Mercersburg COUNTY Penna. STATE Franklin | | | | | |
| 24. FUNERAL DIRECTOR NAME H.H. Griniger | | | | | APRIL 21, 1982 | | | RECORDED, REGISTERED, INDEXED, SERIALIZED, FILED | | | | | |
| DHMH-16 50M 1/81 (VRA 15, 4) | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | 8208470 | |
|---|--|---|-------|--|--|-------------------|--|---|-------|---|--------|--|------|
| | | | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR P.M. | |
| EDWARD A. STRESIWSKI | | | | | | APRIL 8, 1982 | | | | | | 10:41 M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| MALE | | WHITE | | MONTH | DAY | YEAR | 64 | | | MONTHS | DAYS | HOURS | MIN. |
| 7b. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 | | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MARYLAND | | U.S.A. | | 12 - 17 - 1917 | | | Anne Arundel County MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| GLEN BURNIE | | NORTH ARUNDEL Hospital | | | | | | | | | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| 13a. STATE
MD. | | 13b. COUNTY | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | 13e. STREET ADDRESS | | | |
| | | | | | | | | | | 203 CEDAR DRIVE | | | |
| 14. FATHER'S NAME
FIRST | | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME
FIRST | | | ADDRESS | | | | | | |
| EDWARD JOSEPH STRESIWSKI | | | | Anna CATHERINE HATTON | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | | 18. CAUSE OF DEATH
(Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| YES | | WW II | | 218-018528 | | | FAMILY RECORDS | | | | | | |
| 4275 | | Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost. | | DUE TO, OR AS A CONSEQUENCE OF
(b) | | | CARDIAC ARREST | | | SUDDEN | | | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET | | | CITY OR TOWN | | | COUNTY | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | 22c. DATE SIGNED
4/10/82 | |
| 22b. SIGNATURE
T.F. Awalt | | 22d. PHYSICIAN'S NAME
(TYPE OR PRINT) | | | 22e. ADDRESS | | | ATTENDING
PHYSICIAN <input checked="" type="checkbox"/> MEDICAL
DIRECTOR <input type="checkbox"/> STAFF
PHYSICIAN <input type="checkbox"/> | | | | | |
| LAWRENCE F. AWALT | | | | | 3001 SOUTH HANOVER STREET | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIAL
BETH AIR MEM. GAR. | | | 23d. LOCATION
CITY OR TOWN | | | 25a. DATE REC'D. BY REGISTRAR
APR 20 1982 | | | |
| BURIAL | | 4-13-1982 | | | | | BETH AIR | | | REGISTRAR
Frances | | | |
| 24. FUNERAL DIRECTOR
NAME | | ADDRESS | | | | | | | | | | | |
| EVANS FUNERAL CHAPEL | | 8800 HARFORD RD. | | | | | | | | | | | |
| BP_____ | | | | | | | | | | | | | |
| DHMH-1650M 1/B1
(VRA 15, 4) | | | | | | | | | | | | | |

080-518

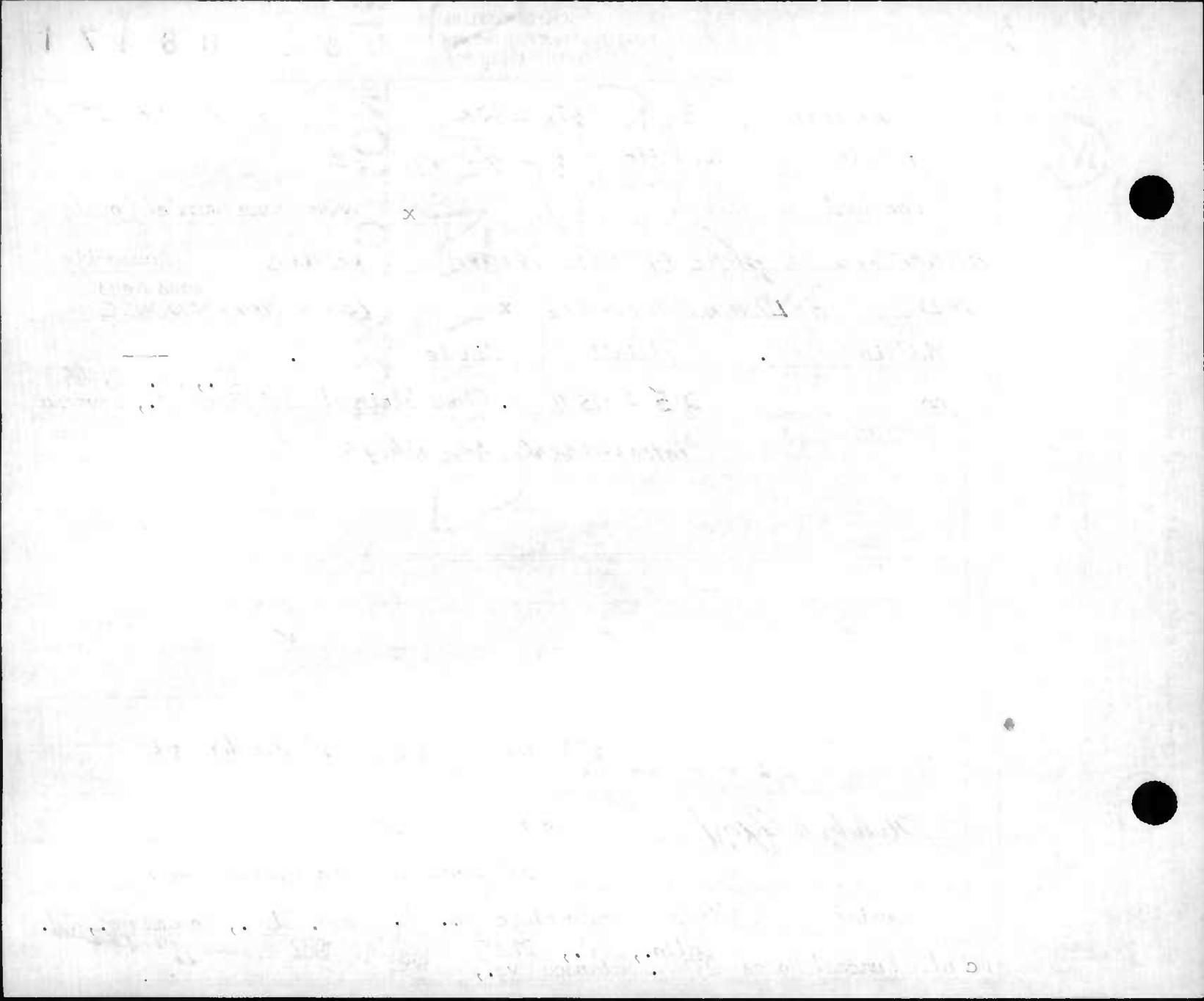
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign here.

referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | 8208471 | | | | | |
|---|--|--|---|----------------|---------------|--|-----|------|--|--------|----------|---|------|--------------------------------------|-------------------|-------------------------------|--|
| 1 - FOR STATE REGISTRAR | | | | | | | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | | | MONTH | DAY | YEAR | 2b. HOUR | | | |
| <u>Lillian E STRIEGEL</u> | | | | | | 4 | 29 | 82 | 5:30 | P.M. | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| Female | | | XX White | | | MONTH | DAY | YEAR | 62 | | | MONTHS | DAYS | HOURS | MIN. | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | <u>XANX Anne Arundel County MD.</u> | | | | | |
| Maryland | | | USA | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| <u>ANNAPOLIS</u> | | | <u>ANNE ARUNDEL GENERAL</u> | | | <u>RETIRED</u> | | | | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS | | | <u>Cross Keys</u> | | |
| MD | | | BALTIMORE | | | BALTIMORE | | | | | | 1304 HARPERHOUSE | | | | | |
| 14. FATHER'S NAME | | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | | FIRST | MIDDLE | LAST | | | | | | |
| <u>Phillip</u> | | | <u>E.</u> | <u>Elliott</u> | <u>Minnie</u> | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | Pk., Md. 21146 | | | | | |
| no | | | <u>215-01-7571</u> | | | <u>E. Grant Striegel</u> | | | 202 Birch (t., Severna | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| IMMEDIATE CAUSE (a) <u>intracerebral hemorrhage</u> | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| - | | | - | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET | | | CITY OR TOWN | | COUNTY | STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8 AM 8/29</u> 1982, to <u>5:30 PM 8/29</u> 1982, that (I) (we) last saw the deceased alive on <u>5:30 PM 8/29 82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Nellie E. Striegel</u> | | | DEGREE
<u>no</u> | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIAL | | 23d. LOCATION
CITY OR TOWN | |
| Burial | | | 5/3/1982 | | | | | | Meadowridge Mem. Pk. | | | Wash. Blvd., Howard | | County | | | |
| 24. FUNERAL DIRECTOR
<u>McCully Funeral Homes</u> | | | Balto. Md., 21225 | | | | | | 25. DATE REC'D. BY MORTUARY REGISTRAR | | | MAY 4 1982 | | | | | |
| | | | 237 E. Patapsco Ave., | | | | | | | | | | | | | | |

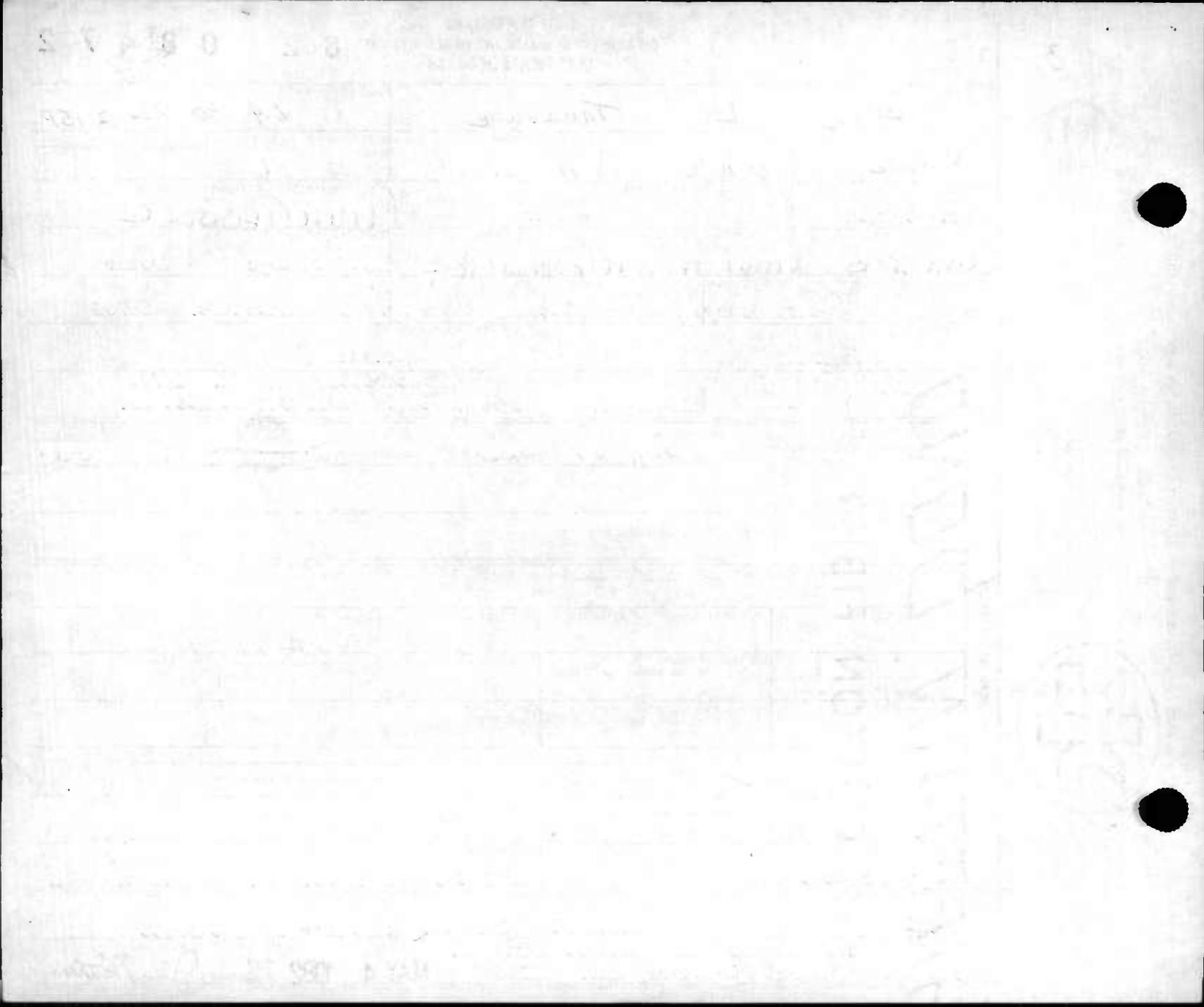


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | 82 08472 | |
|---|--|--|---|------------------|---|--|--------------------------------|---|--|--|--------|---|---------------------|
| | | | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2d. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | |
| Alice L. Tanavage | | | | | | 04 30 82 | | | | | | 2:15PM | |
| 3. SEX | | | 4 RACE | 5. DATE OF BIRTH | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | | white | MONTH | DAY | YEAR | 80 | | | MONTHS | DAYS | HOURS | MIN. |
| 7a. BIRTHPLACE
COUNTRY | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | |
| Pennsylvania | | | USA | | | | | | Prince George | | | Self employed | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12b. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Annapolis | | | Prince George New Carrollton | | | Self employed | | | Grocer | | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS
7902 Powhatan St. 20784 | |
| 14. FATHER'S NAME
Unknown | | | | | | 15. MOTHER'S MAIDEN NAME
Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO.
No --- 213-38-3179 | | | 17. INFORMANT
Beltsville, ADDRESS Md. 20705
Marilyn Winkis 3011 Chapel Hill Dr. | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 week | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>
4275
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.
(b)
(c)
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input type="checkbox"/> No <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>
AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET | | | CITY OR TOWN | | COUNTY | | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) did not view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Jack Teitelbaum</u> | | | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22d. DEGREE
MD | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22e. DATE SIGNED
4/30/82 | | | | | |
| Jack Teitelbaum | | | | | | | | 22e. ADDRESS
2981 Solomons Island Rd. Edgewater, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5/3/82 | | | 23c. NAME OF CEMETERY OR CREMATORIAL
Lake View Memorial Pk | | | 23d. LOCATION
CITY OR TOWN
Eldersburg | | | COUNTY | | STATE
Carroll Md |
| 24. FUNERAL DIRECTOR
NAME
Loring Byers Funeral Directors, Inc. | | ADDRESS
8728 Liberty Rd. Randallstown, Md. 21133 | | | 25a. DATE REC'D. BY REGISTRAR
MAY 4 1982 | | | 25b. REGISTRAR'S SIGNATURE
<u>Dances Jean Nathan</u> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at all times.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 8 4 7 3 | | | |
|---|--|---|-------------------|--|--|---------------------------------|--|---|----------|--------------------------------|-------|--|--|
| | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | | | |
| JESSIE IRENE TAPP | | | | | | 4 1 82 | | | 12 50 PM | | | | |
| 3. SEX | | 4 RACE | | 5 DATE OF BIRTH
MONTH DAY YEAR | | | 6 AGE (IN YEARS LAST BIRTHDAY)
YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | | |
| Female | | White | | 9 9 1915 | | | 166 | | | IF UNDER 24 HRS
HOURS MIN | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 DATE OF DEATH
MONTH DAY YEAR | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | |
| Va. | | USA | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | Anne Arundel | | | | | | |
| 10. CITY OF PLACE OF DEATH
[REDACTED] | | NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 11a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | |
| MD | | MD. MANOR Nursing Home | | Housewife | | | HOME | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. INSIDE/CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 14. STREET ADDRESS | | | | | | |
| MD | | Anne Arundel | | | | | 27 W. WASH ST. | | | | | | |
| 14. MOTHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | 16. SOCIAL SECURITY NO. | | | 17. INFORMANT
ADDRESS | | | | | | |
| M. A. Holson | | Blanche | | 228100375 | | | Pearl E. Carroll # 13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of ovaries</u> | | | | | | | | | | | | | |
| APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| 1830
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last
(b)
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET | | | CITY OR TOWN | | COUNTY | STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Peter A. Rheinstein, MD</u> | | DEGREE | | | ATTENDING
PHYSICIAN <input type="checkbox"/> MEDICAL
DIRECTOR <input type="checkbox"/> STAFF
PHYSICIAN <input type="checkbox"/> | | | 27c. DATE SIGNED
<u>4/1/82</u> | | | | | |
| 22d. PHYSICIAN'S NAME
(TYPE OR PRINT) | | 22e. ADDRESS | | | MARYLAND MANOR NURSING HOME | | | | | | | | |
| PETER A. RHEINSTEIN, MD | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION REMOVAL
(TYPE OR PRINT) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIAL
LOCATION | | | 23d. LOCATION
CITY OR TOWN | | COUNTY | | STATE | | |
| CREMATION | | 4/5/82 | | FF. Givens | | | Brentwood | | P.G. MD. | | | | |
| 24. FUNERAL DIRECTOR
NAME | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| TAYLOR FUNERAL CHAPEL | | Aurora Rd., Md. | | | APR 5 1982 | | | Anne Jean Norton | | | | | |
| DHMH-16 25M
(VRA 15, 4) 1/79 | | | | | | | | | | | | | |

6 v + 8 u

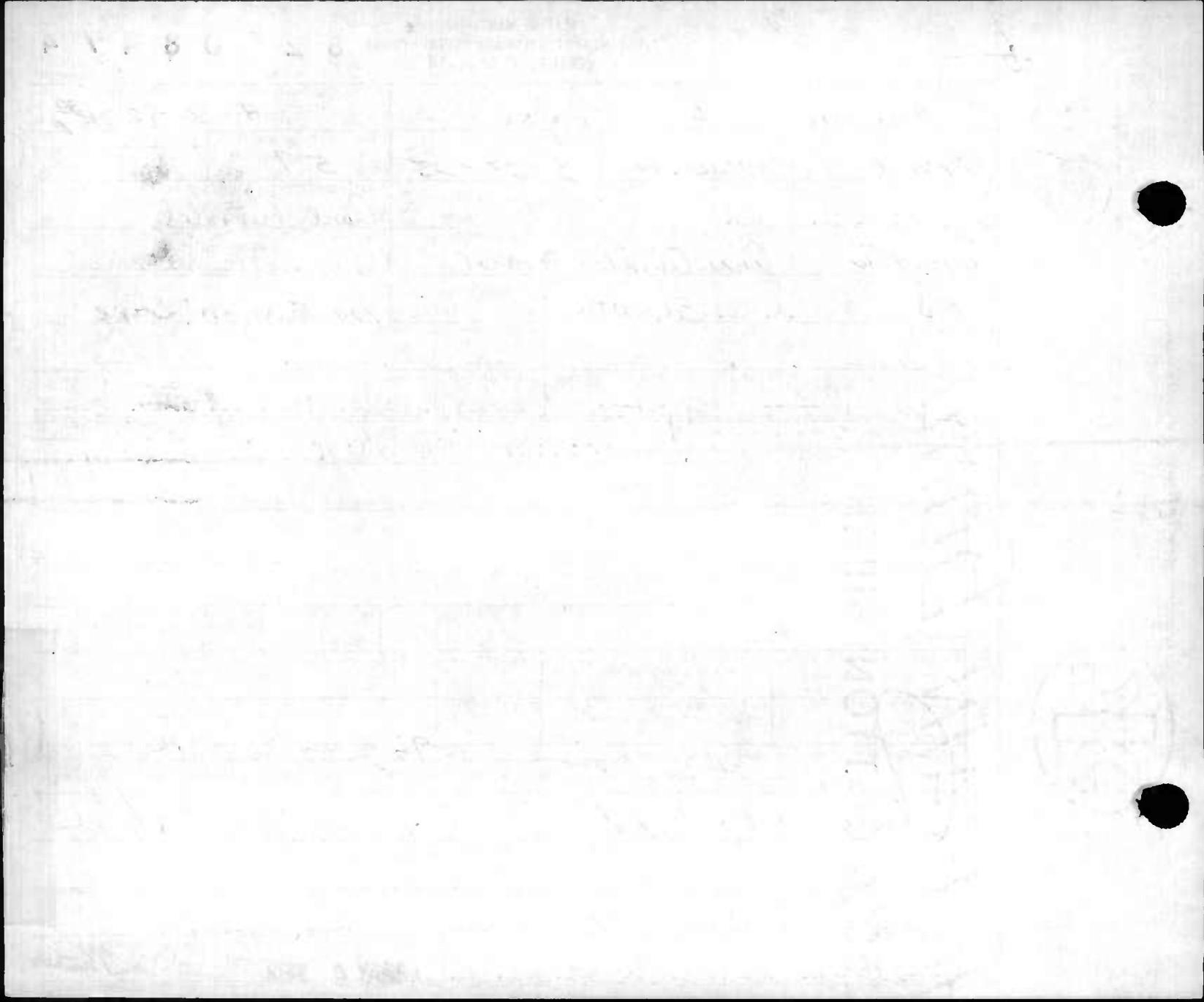
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 82 08474 | | | |
|--|--|--|----------|---|------|---|-----------|---|--------------------------|---|-----------------|--|------|
| | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | |
| <i>Majone</i> | | | <i>L</i> | <i>Taylor</i> | | <i>4-30-82</i> | | | <i>4-30</i> | <i>PM</i> | <i>1:30</i> | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| <i>Female</i> | | <i>Caucasian</i> | | MONTH | DAY | YEAR | <i>57</i> | | | MONTHS | DAYS | HOURS | MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| <i>Fon De Lac Wisco.</i> | | <i>USA</i> | | | | | | <i>Rose Arundel</i> | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| <i>Annapolis</i> | | <i>Rose Arundel General</i> | | <i>V/Pres. 1st Federal Banking</i> | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | | | |
| <i>MD</i> | | <i>A.A. Co.</i> | | <i>Edgewater</i> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | <i>106 Tarragon Lane</i> | | | <i>LAST</i> | |
| 14. FATHER'S NAME
FIRST | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME
FIRST | | | MIDDLE | | | <i>Wells</i> | |
| <i>Alfred</i> | | <i>R.</i> | | <i>Hansen</i> | | <i>Iva</i> | | | <i>L.</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | | | | | ADDRESS | | | |
| <i>no</i> | | <i>573-22-5632</i> | | <i>Thomas H. Taylor</i> | | | | | | <i>105 Tarragon Ln. Edgewater, MD</i> | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for items 18a, 18b, and 18c.
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Intracerebral hemorrhage</i> | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>1 day.</i> | |
| 4310
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.
(b)
(c) | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET | | CITY OR TOWN | | COUNTY | | STATE | | | |
| | | | | <i>96</i> | | <i>4/30</i> | | <i>1982</i> | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from
saw the deceased alive on <i>4/30/82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) did not view the body after death. | | 22b. SIGNATURE <i>Juliette M. Mohr M.D.</i> DEGREE | | | | | | | | | | 22c. DATE SIGNED <i>8/1/82</i> | |
| | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | | | | 23d. LOCATION
CITY OR TOWN | | | |
| <i>Burial</i> | | <i>5/3/82</i> | | <i>Lakemont Cemetery</i> | | | | | | <i>Davidsonville, Md.</i> | | | |
| 24. FUNERAL DIRECTOR
NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| <i>Hardesty Funeral Home 12 Ridgely Ave. Ann. Md.</i> | | | | <i>21 MAY 4 1982</i> | | | | | | <i>Deacon Jean Warthen</i> | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. | 2 | 0 8 4 7 5 | | | | | | | | | |
|--|--|-------------------------------------|---|--|--|--|---|---|-----------------------------------|-------------------------------|--|---|------------------|--------------------------------|--------------------------------------|------------------|----------------|--------------|--|----------|-----|--|--|
| 1- STATE REGISTRAR | | | FIRST | | | MIDDLE | | | LAST | | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED | | | MONTH DAY YEAR | | | 2b. HOUR | | | | | |
| I. DECEASED NAME
(TYPE OR PRINT) | | | ARNOLD | | | D. | | | THOMAS | | | <input checked="" type="checkbox"/> 4 17 1982 P M | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH
MONTH DAY YEAR | | | 6. AGE (IN YEARS)
LAST BIRTHDAY | | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | 2c. DATE
PRONOUNCED
DEAD | | | MONTH DAY YEAR | | | 2d. HOUR | | | |
| MALE | | WHITE | | Nov. 24, 1909 | | | 72 yrs. | | | | | | | 4 17 1982 P M | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR
PROVINCE, COUNTRY) | | | New Jersey | | | 7b. CITIZEN OF WHAT COUNTRY? | | | U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | Anne Arundel | | | MD. | | |
| 10. CITY OR TOWN OF DEATH | | | Annapolis | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | Anne Arundel General Hospital | | | 12a. USUAL OCCUPATION TYPE OF WORK | | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | Transit | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS | | | 5004 38th Avenue | | | | | | | | | | |
| Maryland | | Prince Geo. | | Hyattsville | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST | | | MIDDLE | | | LAST | | | 15. MOTHER'S MAIDEN NAME
FIRST | | | MIDDLE | | | LAST | | | | | | | | |
| George | | | A. | | | Thomas | | | Charlotte | | | Dudley | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | 324 Highland Drive | | | | | | | | | | | | | | |
| No | | | 579 03 4594 | | | Bettye C. Tuel | | | Edgewater, Md. | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>Carcinomatosis</i>
1990
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | months | | | | | | | | | | | |
| Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last. | | | | | | | | | | | | | | | | | | | | | | | |
| (b) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | | | | | | | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET | | | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | TITLE (SPECIFY)
<i>John Hall</i> | | | | | | | | | | M.D. | | Depot 9 | | MEDICAL EXAMINER | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS | | | | | | | | | | <i>Glenelg, Md.</i> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIUM | | | 23d. LOCATION
CITY OR TOWN | | | 23e. COUNTY | | | STATE | | | | | | | | |
| Burial | | | 4/20/82 | | | Ft. Lincoln Cemetery | | | Brentwood | | | P.G. | | | Maryland | | | | | | | | |
| 24. FUNERAL DIRECTOR
ADDRESS | | | Frankis Gasch's Sons Funeral Home, P.A. | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | |
| | | | | | | APR 19 1982 | | | | | | | | | | | | | | | | | |

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

• • • *small brownish-yellow flowers*
• • • *small brownish-yellow flowers*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSPORT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED. WILLIAM REESE & SONS MORTUARY, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

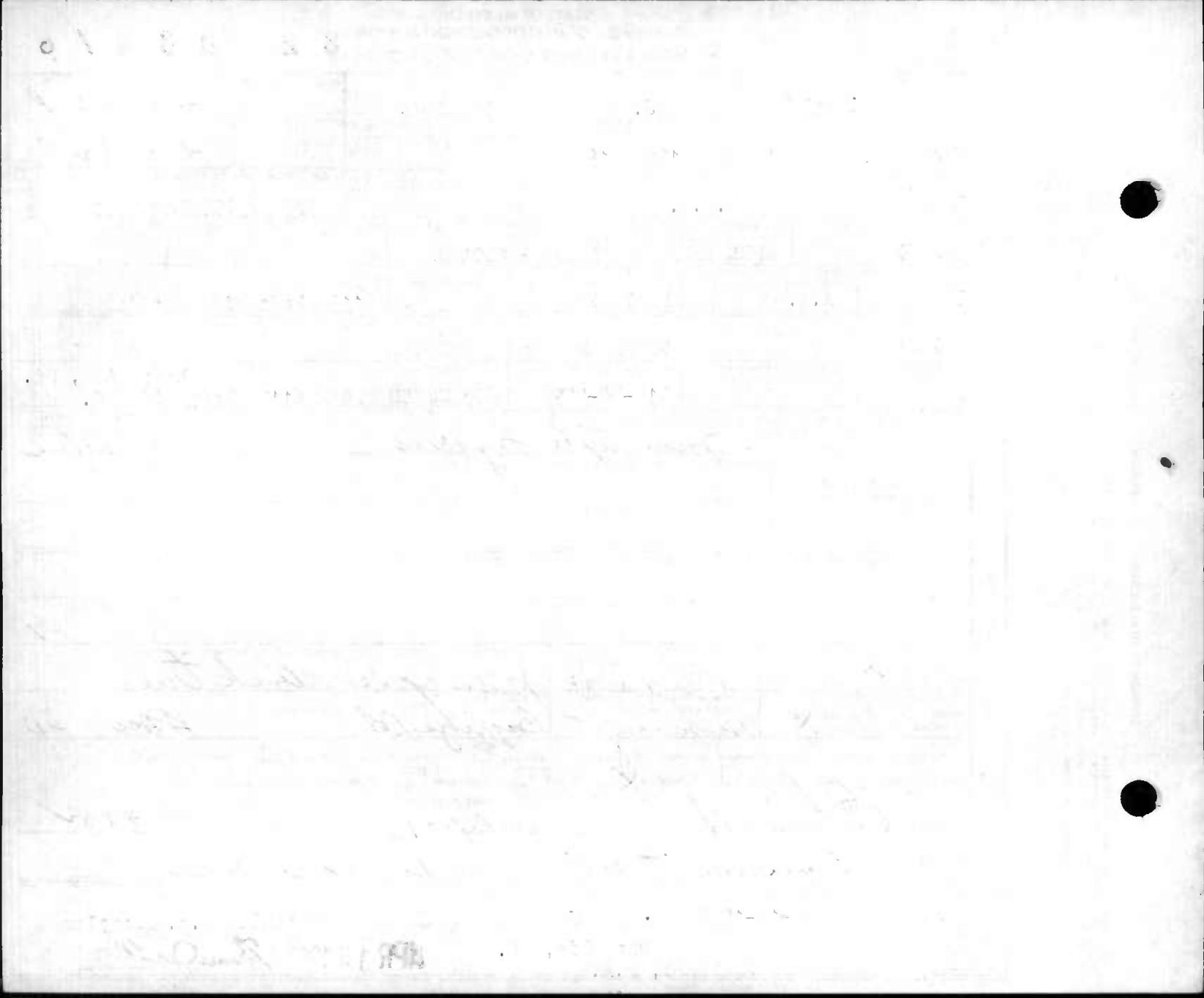
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8208476 | | |
|---|---------|---|--|-------------------------------------|--|--|------|---|---|-----------------------|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN
OF
DEATH
ESTI-
MATED | | | MONTH DAY YEAR | 2b. HOUR
P.M. | | |
| YVETTE J. THOMPSON | | | | | | 48 | 1982 | P | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | 6. AGE (IN YEARS
LAST BIRTHDAY) | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN | 2c. DATE
PRONOUNCED
DEAD | | | MONTH DAY YEAR | 2d. HOUR
P.M. | | |
| FEMALE | NEGRO | 7 28 1962 | 19 yrs. | | | 48 | 1982 | P | | | | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED
WIDOWED
XX | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNE ARUNDEL GENERAL HOSPITAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
SHADY SIDE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
6113 Shady Side Road | | | | |
| 14. FATHER'S NAME
FIRST WILSON | | MIDDLE | LAST THOMPSON | 15. MOTHER'S MAIDEN NAME
REBECCA | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
214-84-7792 | | 17. INFORMANT
REBECCA THOMPSON | ADDRESS
Shady Side, Md.
6113 Shady Side Rd. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) <i>multiple injuries</i>
DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
goe rise to immediate
cause (a) stating the under-
lying cause last.

(b)
DUE TO, OR AS A CONSEQUENCE OF

(c) | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>fallen</i> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 04 8 82 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)
<i>multiple struck tree</i> | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)
<i>highway</i> | | | 21f. LOCATION
STREET
<i>Bayfield Rd</i> | | | CITY OR TOWN
<i>Owensville</i> | COUNTY
<i>A.A.</i> | STATE
<i>Maryland</i> | |
| 22a. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | TITLE (SPECIFY)
M.D. <i>Deputy</i> | |
| EXAMINER'S NAME
(TYPE OR PRINT)
<i>E. Lindquist</i> | | | | | | | | | | | MEDICAL EXAMINER
<i>Anne Thompson</i> | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
4-12-1982 | | | 23c. NAME OF CEMETERY OR CREMATORY
CHEWS CHURCH CEMETERY | | | 23d. LOCATION
CITY OR TOWN
Owensville | | | |
| 24. FUNERAL DIRECTOR
NAME
WILLIAM REESE & SONS MORTUARY, P.A. | | | ADDRESS
Annapolis, Md. | | | 25a. DATE REC'D. BY REGISTRAR
APR 13 1982 | | | 25b. REGISTRAR'S SIGNATURE
<i>Frank Jan Martin</i> | | | |
| BP _____ | | | | | | | | | | | | |
| DHMH - 17
(VR A15 ME (5))
30M 7/73 | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | 8 2 0 8 4 7 7 | REG. NO. | | |
|---|--|--|---|--|---|---|--|--|---|--|--|--------------------------------------|----------|--|---|
| 1 - STATE REGISTRAR | | | 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2d. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | | |
| | | | <i>Joseph</i> | | | <i>Winfield Tracey, Jr.</i> | | | <i>April 16, 1982</i> | | | <i>11:41 A.M.</i> | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH
MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | | |
| <i>Male</i> | | | <i>White</i> | | | <i>Oct. 14, 1923</i> | | | <i>58</i> | | | MONTHS DAYS HOURS MIN | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | |
| <i>Maryland</i> | | | <i>U.S.A.</i> | | | | | | <i>Anne Arundel County</i> | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| <i>Glen Burnie</i> | | | <i>North Arundel Hospital</i> | | | <i>Disabled</i> | | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS | | | |
| <i>Maryland</i> | | | <i>Anne Arundel</i> | | | <i>Pasadena</i> | | | | | | <i>1643 Fairview Beach Rd. 21122</i> | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | |
| <i>Joseph</i> | | | <i>Carolyn</i> | | | <i>216-18-9897</i> | | | <i>Mrs. Ruth J. Tracey</i> | | | <i>Same as #13</i> | | | |
| 18. CAUSE OF DEATH: (Enter only one cause per line for item 18, part I and II)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Hyperkalemia Shock. Lactic Acidosis</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
<i>5715</i>
(b) <i>Detached Varicose Bleeding</i>
(c) <i>Second Embolism</i> | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 days</i>
<i>day</i>
<i>1/1</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<i>Severe Varicose Veins with ulcer.</i> | | | | | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | | | <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> | | | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4/19/82</i> , to <i>4/16/82</i> , that (I) (we) last saw the deceased alive on <i>4/16/82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>M. J. Murphy Jr.</i> | | | | | | | | | | | | | | | 22c. DATE SIGNED
<i>4/29/82</i> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | | | |
| <i>Michael Garahy, M.D.</i> | | <i>8206 Fort Smallwood Rd., Balto., Md. 21226</i> | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | | 23c. NAME OF CEMETERY OR Crematory | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | |
| <i>Burial</i> | | <i>4/20/1982</i> | | | <i>Maryland Veteran Cem.</i> | | | <i>Crownsville Anne Arundel</i> | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | 24. DATE REC'D. BY REGISTRAR | | | 24. REGISTRAR'S SIGNATURE | | | | | | | | | | |
| <i>McCully Funeral Home of Pasadena</i> | | <i>4/22/1982</i> | | | <i>James J. Garahy</i> | | | | | | | | | | |

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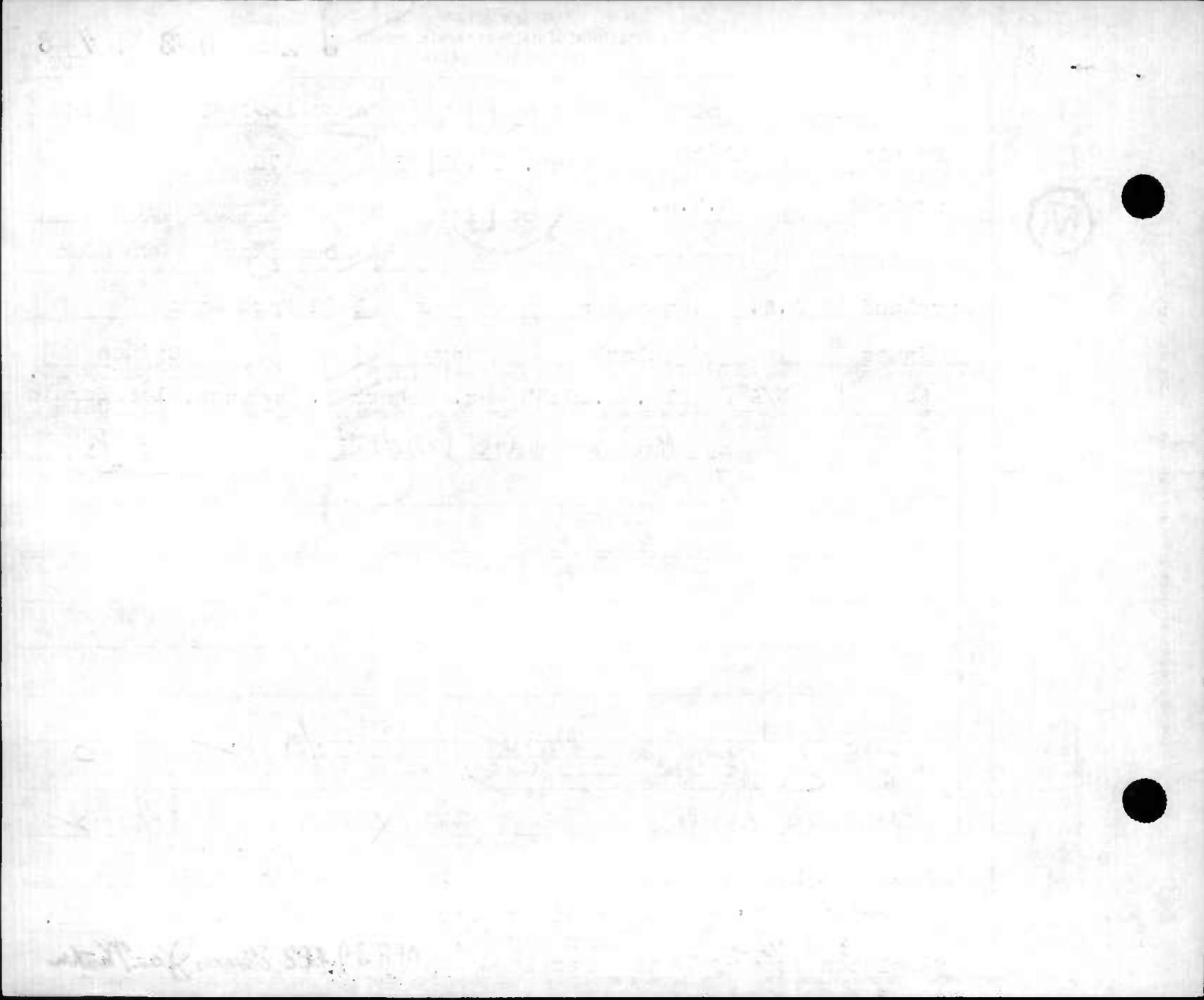
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, this medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | 8 2 0 8 4 7 8
REG. NO. | EDT | |
|--|--|---|-------------------------------------|---|---|---|---|---|----------------------------------|---|--|---|-----|--|
| 1. FOR
1 - STATE
REGISTRAR | | | 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | |
| | | | MARY AGNES UNDUTCH | | | | | | APRIL 28, 1982 | | | 4:30 M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH
MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | | |
| Female | | White | | Sept. 16, 1905 | | | | | | | | | | |
| BIRTHPLACE
COUNTRY
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY | | | MD. | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | 12a. USUAL OCCUPATION
Homemaker | | | 12b. KIND OF BUSINESS OR
INDUSTRY
Own Home | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Pasadena | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
1492 Park Lane | | | | | | |
| 14. FATHER'S NAME
James | | LAST
Clark | | 15. MOTHER'S MAIDEN NAME
Mary | | LAST
Cadden | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT
(SON)
Mr. Robert E. Undutch, Glen Burnie
21067 | | ADDRESS
908 Edgerly Rd. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4360</u>
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.
(b),
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
3wks | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET | | | COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/1/82</u> , 19 <u>82</u> , to <u>4/28/82</u> , 19 <u>82</u> , that (we) last
saw the deceased alive on <u>4/21/82</u> , 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above. (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Lorraine M. Dailey</u> | | 22c. DEGREE | | | | | | ATTENDING MEDICAL STAFF
PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | | 22d. DATE SIGNED
<u>4/28/82</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LORAINA M. DAILEY, M.D. | | 22e. ADDRESS
8667 Fort Smallwood Road
Pasadena, Maryland 21122 | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3'May 82 | | 23c. NAME OF CEMETERY OR CREMATORIAL
Baltimore National | | | 23d. LOCATION
CITY OR TOWN
Baltimore, MD. | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Singleton Funeral Home | | ADDRESS
Glen Burnie,
Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
APR 29 1982 | | | REGISTRAR'S SIGNATURE
<u>Frances Jean Hartman</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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Item 5 g566 4/28/82 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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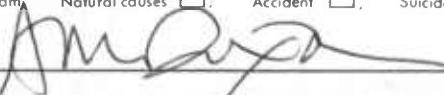
REG. NO.

| | | | | | | | | | | | | |
|---|---|--------------------------------------|--|--|----------------------------------|--|--|--|--------------------------|----------|---------------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | | |
| Robert William Vayda | | | | | | 4/11/82. | | | | 11 A.M. | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 10th | 22nd | 1929 | 6. AGE (IN YEARS LAST BIRTHDAY) | 52 | IF UNDER 1 YEAR
MONTHS | IF UNDER 24 HRS
HOURS | | | |
| Male | White | April 11, 1982 | | | | YRS | | DAYS | MIN. | | | |
| 7a. BIRTHPLACE
COUNTRY | 7b. STATE OR FOREIGN | 7c. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> | NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> | DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| NY | USA | | | | | Anne Arundel | | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | | |
| Annapolis | 3051 Minion Road | | | | | Attorney | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | | | 13e. STREET ADDRESS | | | | | | |
| MD | A.A. | Annapolis | YES <input type="checkbox"/> | NO <input checked="" type="checkbox"/> | | 3051 Minion Road | 21403 | | | | | |
| 14. FATHER'S NAME | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | | ADDRESS | | | | | |
| Alexander Vincent Vayda | | | | Martha C. Williams | | | Same as #13 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | |
| Yes 1951-1971 | 108-22-9968 | | | | | Louise M. Vayda | Minutes | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular fibrillation | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic heart disease | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | YES <input type="checkbox"/> | NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED

WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | 21f. LOCATION
STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____ | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/1/82 to 4/11/82, that (I) (we) last saw the deceased alive on 4/1/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
General physician | DEGREE
M.D. | | | | | ATTENDING <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
4/11/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS
8 EVERGREEN LANE SEVENNA PARK | | | | | | | | | | | |
| GUNNAR CHURCH | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORIUM | | | | | 23d. LOCATION
CITY OR TOWN | 23e. COUNTIES | | | | |
| Burial | April 16, 1982 | Arlington National Cemetery | | | | | Arlington | VA | | | | |
| 24. FUNERAL DIRECTOR
NAME | 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | |
| John M. Taylor & Sons - Annapolis, MD | APR 15 1982 | | | | | | | | | | John M. Taylor & Sons - Annapolis, MD | |

IMH-1650M1/81
(VRA 15, 4)

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 5 DAYS, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|-------------------------------------|-----|-------------------------------------|----------|-------|-----|------|----------|--|
| FOR
1 - STATE
REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | 2 | 0 | 8 | 4 | 8 | 0 | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED | | MONTH | DAY | YEAR | 2b. HOUR | | | | | |
| | | PETER | | Vince | | VIZBARAS | | <input checked="" type="checkbox"/> | | 4 | 17 | 19 | 82 | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS)
LAST BIRTHDAY
31 YRS. | | IF UNDER 1 YR.
MONTHS | | IF UNDER 24 HRS.
DAYS HOURS MIN. | | 2c. DATE
PRONOUNCED
DEAD | | MONTH | DAY | YEAR | 2d. HOUR | |
| Male | | White | | Jan. 14, 1951 | | | | | | | | <input checked="" type="checkbox"/> | | 4 | 17 | 19 | 82 | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED
<input type="checkbox"/> NEVER MARRIED
<input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 9c. DATE
PRONOUNCED
DEAD | | 9d. HOUR | | | | | | | | |
| Md. | | U.S.A. | | <input type="checkbox"/> WIDOWED
<input type="checkbox"/> DIVORCED | | Anne Arundel County | | <input type="checkbox"/> | | 9:43 | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | | | | | | | | |
| Glen Burnie | | North Arundel Hospital | | Mechanic | | Aircraft | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | | | | | | | | | |
| Md. | | Anne Arundel | | Pasadena | | <input checked="" type="checkbox"/> | | 323 Dorchester Rd. 21122 | | | | | | | | | | |
| 14. FATHER'S NAME | | FIRST | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | |
| | | Vincas | | | | Vizbaras | | Linda | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | |
| No | | 214-56-2103 | | Vincas Vizbaras | | same as 13 | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Positional asphyxia with chest compression
9630 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which
gave rise to immediate
cause (a) stating the <u>under-</u>
lying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
Obesity and hepatomegaly | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR
P.M. 4/17/82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject pinned face-down by police | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)
house | | 21f. LOCATION
STREET 323 Dorchester Rd. Pasadena A.A. Co., Md.
CITY OR TOWN
COUNTY
STATE | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE  | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) Ann M. Dixon, M.D. | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE
Burial 4/28/1982 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Park | | 23d. LOCATION
CITY OR TOWN
Glen Burnie Anne Arundel Md. | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
McCully F. H. Mountain & Tick Neck Rds. 21122 | | ADDRESS
Pasadena, Md. | | 25a. DATE REC'D. BY REGISTRAR
APR 29 1982 | | 25b. REGISTRAR'S SIGNATURE
 | | | | | | | | | | | | |
| DHMH - 17
(VR A15 ME (5))
15MA 2/80 | | | | | | | | | | | | | | | | | | |

scribble copy 29 9/20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 8 2 0 8 4 8 1
E.S.T. | |
|---|--|--|---|--|--|---|--|--|--|--|--|---|---|
| 1 - STATE REGISTRAR | | | 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | |
| | | | ANNE PARKS | | | von Bohlar VONBOLHAR | | | APRIL 18, 1982 | | | 3:32A.M. | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH
MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| Female | | | White | | | Oct. 24, 1908 | | | 73 YRS | | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| California | | | U.S.A. | | | | | | ANNE ARUNDEL COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| GLEN BURNIE | | | NORTH ARUNDEL HOSPITAL | | | | | | Homemaker | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS | |
| Maryland | | | A.A. Co. | | | Severna Park | | | | | | 17 Ridge Rd. 21146 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | Parks | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | |
| Unknown | | | | | | UNKNOWN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | | 17. INFORMANT | | | ADDRESS | | | | |
| No | | | 552.14.9248 | | | William J. Corddry, Jr. | | | 19 Ridge Rd. Severna Pk, Md. 21146 | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)].
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i> | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| 4360
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b),
{ DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | | |
| 19a. MEDICAL CERTIFICATION | | | 19b. DATE OF OPERATION | | | 19c. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Apr. 13 82</i> to <i>Apr. 18 82</i> , that (we) last
saw the deceased alive on <i>Apr. 17 82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) did not view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Charles J. Wu, M.D.</i> | | | | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
<i>Apr. 18, 1982</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | CHARLES J. WU, M.D. | | | 22e. ADDRESS | | | 7845 OAKWOOD ROAD, SUITE 204
GLEN BURNIE, MARYLAND 21061 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | |
| Cremation | | | 4/19/1982 | | | Green Mount Crematory | | | Baltimore Maryland | | | | |
| 24. FUNERAL DIRECTOR
<i>Walt Proffitt, Jr.</i> | | | | | | APPROVED BY REGISTRAR'S SIGNATURE
<i>APR 20 1982 Jones Jan Whitten</i> | | | | | | | |

1850-58

1850-58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8208482 | | | |
|--|--|---|-----------|---|--------------------------|---|--|-------------------------------|---|--|-----------------|------------------|--|
| | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a DATE OF DEATH | | | MONTH | DAY | YEAR | 2b HOUR | |
| <u>ALBERT</u> | | | <u>H.</u> | <u>WAGNER</u> | | <u>4-4-82</u> | | | <u>APR</u> | <u>4</u> | <u>1982</u> | <u>9:30 P.M.</u> | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| <u>MALE</u> | | <u>WHITE</u> | | MONTH <u>SEPT.</u> DAY <u>5</u> YEAR <u>1907</u> | | 74 | | | YEARS | MONTHS | DAYS | HOURS | |
| 7. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | | |
| <u>MARYLAND</u> | | <u>U.S.A.</u> | | | | <u>ANNE ARUNDEL</u> | | | <u>KOON'S FORD</u> | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b KIND OF BUSINESS OR
INDUSTRY | | | | |
| <u>ANNAPOLIS</u> | | <u>ANNE ARUNDEL GEN. HOSP.</u> | | | | <u>PARTS MANAGER</u> | | | <u>513 BROADWATER RD.</u> | | | | |
| 13a STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS | | | | |
| <u>MARYLAND</u> | | <u>ANNE ARUNDEL</u> | | <u>ARNOLD</u> | | | | | <u>513 BROADWATER RD.</u> | | | | |
| 14. FATHER'S NAME
FIRST | | MIDDLE | | LAST | 15. MOTHER'S MAIDEN NAME | | | 16. ADDRESS | | | | | |
| <u>ALBERT</u> | | <u>F.</u> | | <u>WAGNER</u> | <u>KATHERINE</u> | | | <u>(SAME AS 13)</u> | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES OR UNKNOWN) | | (YES OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | 18. APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | |
| <u>YES</u> | | <u>WW II</u> | | <u>212-05-9644</u> | | <u>ANNA WAGNER</u> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) _____
(c) _____ | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
<u>B</u> | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET | | CITY OR TOWN | | CITY OR TOWN | | COUNTY | | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-</u> , 19 <u>82</u> , to <u>4-6</u> , 19 <u>82</u> , that <u>we</u> last
saw the deceased alive on <u>4-2</u> , 19 <u>81</u> , and that in <u>our</u> (our) opinion death occurred on the date and hour and from the causes stated
above. <u>I</u> (we) did (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>G. Mitchell MD</u> | | | | | | | | | | | | | |
| DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | | | | | |
| 22c. DATE SIGNED
<u>4-6-82</u> | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS
<u>205 Ridge Ave, Annapolis MD</u> | | | | | | | | | | | |
| <u>G. Mitchell MD</u> | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIUM | | 23d. LOCATION
CITY OR TOWN | | 23e. LOCATION
CITY OR TOWN | | 23f. LOCATION
CITY OR TOWN | | | |
| <u>BURIAL</u> | | <u>APRIL 7, 1982</u> | | <u>GLEN HAVEN CEMETERY</u> | | <u>GLEN BURNIE</u> | | <u>ANNE ARUNDEL</u> | | <u>MD.</u> | | | |
| 24 FUNERAL DIRECTOR
NAME | | 25a. DATE DECD. BY REGISTRAR
<u>APR 8 1982</u> | | 25b. DATE REC'D. BY MEDICAL EXAMINER
<u>APR 8 1982</u> | | | | | | | | | |
| <u>ROBERT S. BARRANCO</u> | | | | | | | | | | | | | |

— 8 —

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 8 4 8 3 | | | | | | | |
|--|--|--|---|--|--|--|--|--|---|--|--------|--------------------------------------|-------|---|--|--|--|
| | | | | | | | | | | REG. NO. | | | | | | | |
| 1. FOR
- STATE
REGISTRAR | | | FIRST
GERTHA | | | MIDDLE
Virginia | | | LAST
WATCHMAN | | | 2a DATE OF DEATH
APRIL 14, 1982 | | 2b HOUR
8:41 P.M. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | | | | | | | | | | | | | |
| 3. SEX
Female | | | 4. RACE
White | | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 9, 1910 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS | | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | | | | | |
| 10 CITY OR TOWN OF DEATH
GLEN BURNIE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING TIME)
(Ret.) Receptionist | | | 12b KIND OF BUSINESS OR
INDUSTRY Funeral Home | | | | | | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
A.A. | | | 13c. CITY OR TOWN
Glen Burnie | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS
205 Kent Road | | (Glen Gardens) | | | |
| 14. FATHER'S NAME
FIRST
Frederick R. | | | MIDDLE
Bradley | | | LAST | | | 15. MOTHER'S MAIDEN NAME
Sarah C. | | | | | LAST
Maxfield | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WORK DATES)
N/A | | | 17. INFORMANT (Husband) ADDRESS
Mr. Frederick L. Watchman | | | Same as # 13 | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

410P
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last. | | | | | | | | | | Myocardial Infarction
sudden
{ DUE TO, OR AS A CONSEQUENCE OF
(b),
Ischemic Heart Disease
} DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Year | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET | | | CITY OR TOWN | | COUNTY | | STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from
saw the deceased alive on April 19, 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | to 4-18-82 | | | | | | | |
| 22b. SIGNATURE
<i>JACK I. STERN</i> | | | DEGREE | | | ATTENDING
PHYSICIAN <input checked="" type="checkbox"/> MEDICAL
DIRECTOR <input type="checkbox"/> STAFF
PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
4-15-82 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JACK I. STERN, M.D., P.A. | | | 22e. ADDRESS
300 HOSPITAL DRIVE SUITE 135
GLEN BURNIE, MARYLAND 21061 | | | | | | | | | | | | | | |
| 23a. BURIAL/CREMATION/REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
19 Apr. 82 | | | 23c. NAME OF CEMETERY OR CREMATORIAL
Glen Haven Mem.Pk. | | | 23d. LOCATION
CITY OR TOWN
Glen Burnie, A.A., MD. | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Singleton Funeral Home | | | ADDRESS
Glen Burnie,
Maryland | | | 25a. DATE REC'D. BY REGISTRAR
APR 16 1982 | | | 25b. REGISTRAR'S SIGNATURE
<i>James J. Smith</i> | | | | | | | | |

Q 228 31 99A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 8208484 | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--------|---|--------------|-------------------------------------|------------|--------------------|
| 1. FOR
STATE
REGISTRAR | | | FIRST
PAUL | | | MIDDLE
C. | | | LAST
WELLER | | | 2a. DATE OF DEATH
4-3-82 | MONTH
APR | DAY
4 | YEAR
82 | 2b. HOUR
4 P.M. |
| I. DECEASED NAME
(TYPE OR PRINT) | | | | | | | | | | | | | | | | |
| 3. SEX
MALE | | | 4. RACE
CAUCASIAN | | | 5. DATE OF BIRTH
M 2-15-17 | | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | | | IF UNDER 1 YEAR
MONTHS | | IF UNDER 24 HRS.
DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
Anne Arundel Gen. Hosp. | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Business Agent-Teamster | | | 12b. KIND OF BUSINESS OR INDUSTRY
Business Agent-Teamster | | | | | | | |
| 13a. STATE
Md. | | | 13b. COUNTY
Anne Arundel | | | 13c. CITY OR TOWN
Lothian | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS
70-Lions Creek Rd. | | | | |
| 14. FATHER'S NAME
FIRST
Paul | | | MIDDLE
E. | | | LAST
Weller | | | 15. MOTHER'S MAIDEN NAME
FIRST
Helen | | | MIDDLE
M. | | LAST
O'Brien | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
WWII | | | 17. INFORMANT
Beulah Weller - above address | | | ADDRESS | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congestive Heart Failure (Wife)</u> | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | |
| 4149
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.
(b) <u>Car. Art - Disease</u> | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>E. Coli Pneumonia</u> | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET | | | CITY OR TOWN | | COUNTY | | STATE | | | |
| 22a. I certify that (in this hospital) attended the deceased from <u>3-12-82</u> to <u>4-3-82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated below. The deceased was born <u>1982</u> and died <u>1982</u> .
below, and did not die of the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>J. Nalley</u> | | | 22c. DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22d. DATE SIGNED
4-3-82 | | | | | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22f. ADDRESS | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
4/6/1982 | | | 23c. NAME OF CEMETERY OR CREMATORIAL
Ft. Lincoln Cem. | | | 23d. LOCATION
CITY OR TOWN
Brentwood | | | COUNTY
Pr. Geo. Md. | | STATE | | |
| 24. FUNERAL DIRECTOR
NAME
Nalley's F.H. Inc. | | | ADDRESS
Mt. Rainier, Md. | | | 25a. DATE REC'D. BY REGISTRAR
APR 12 1982 | | | 25b. REGISTRAR'S SIGNATURE
<u>James J. Jackson</u> | | | | | | | |

6 1 3 0 6

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IMPORTANT: If item 21 is marked as "any injury, or after traumatic event, the medical examiner must be notified."

MEDICAL CERTIFICATION

**1 - FOR
STATE
REGISTRAR**

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 0 8 4 8 5

REG. NO.

| | | | | | | | | | | | | |
|---|--|---|---|---|---|---|--|---|---|--|------------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR | | |
| SAMUEL A. WELSH, SR. | | | | | | APRIL 18, 1982 | | | 3:30 PM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | 7. IF UNDER 1 YEAR | | |
| MALE | | WHITE | | MONTH | DAY | YEAR | 74 | YRS. | | | IF UNDER 24 HRS | |
| 8. BIRTHPLACE
COUNTRY | | 9. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Md | | USA | | | | | A. A. Co. | | | MD. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Glen Burnie | | N.A.H. | | | Sales | | | Food | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | 13f. APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| Md | | AA | | Glen Burnie | | No | | 619 Marshall Rd. | | 30 minutes | | |
| 14. FATHER'S NAME
FIRST | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME
FIRST | | MIDDLE | | LAST | | |
| Wm | | E. | | Welsh | | Murphy | | | | Unknown | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | | 17. INFORMANT | | | ADDRESS | | | |
| No | | | 214019616A | | | Mrs. A. L. Welsh - Alone | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
4292 30 minutes
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Arteriosclerotic Cardiovascular</u> over 6 years
} Disease
(c) _____ | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I
<u>Chronic debilitatin & old cerebrovascular accident since 1976</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET | | | CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/31/76</u> to <u>4/18/82</u> , that (I) (we) last
saw the deceased alive on <u>April 11, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>B. A. Alonso, M.D.</u> | | DEGREE
M.D. | | | ATTENDING PHYSICIAN <input type="checkbox"/> | | MEDICAL DIRECTOR <input type="checkbox"/> | | STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>4/18/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>B. A. Alonso</u> | | 22e. ADDRESS
<u>1406 CRAIN HWY. GLEN BURNIE,</u> | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE
<u>4/21/82</u> | | 23c. NAME OF CEMETERY OR CREMATORIAL
<u>Cedar Hill</u> | | | 23d. LOCATION
CITY OR STATE
<u>Baltimore, Md.</u> | | 23e. COUNTRY
<u>USA</u> | | | |
| 24. FUNERAL DIRECTOR
NAME
<u>John J. Banano</u> | | 24b. ADDRESS
<u>Severna Park</u> | | | 24c. DATE
<u>APR 22 1982</u> | | | 24d. LOCATION
CITY OR STATE
<u>Baltimore, Md.</u> | | | | |

C. S. P. S. U. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 08486

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR; PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | | | | | | | | | | | | | | | |
|--|---------|--|--------|----------|---|--|--------|---|--------------|--------------------------------|-------------------------------------|-------------------------------------|----------|--|--|--|--|
| 1- STATE REGISTRAR | | 2- DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR | | | | | | | | | | 2b HOUR | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | | MIDDLE | | | LAST | | | OF ESTI-
DEATH MATED | | 4 4 1982 | | | | |
| Maurice E Whims | | | | | | | | | | | <input checked="" type="checkbox"/> | | M | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | | | 6. AGE (IN YEARS
LAST BIRTHDAY) | | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE
MONTH DAY YEAR | | 2d HOUR | | | |
| male | black | 6 26 52 | | | 29 yrs | | | | | | | 4 4 1982 | | M | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Md. | | USA | | | | | | Anne Arundel County | | | | am | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | | | | | |
| Glen Burnie | | North Arundel Hospital | | | Chaplain | | | Horse Van | | | | MD | | | | | |
| 13a. STATE | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | ADDRESS | | | | | |
| Md. | | Balto. | | | Phoenix | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Blenheim Rd | | Blenheim Rd | | | | | |
| 14. FATHER'S NAME | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | McKay | | | | | |
| Charles | | Wm | | Whims sr | YVONNE | | | 112265055 | | Charles Whims sr | | Phoenix, Md | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cranio-cerebral injury</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
3:AM 4/4 19 82 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
driver in auto/auto collision | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)
roadway | | | 21f. LOCATION | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | |
| | | | | | Rt#170 and Wiecker Rd, Svern, AA County, MD | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | DATE SIGNED 4/4/82 | | | |
| ACTUAL SIGNATURE <u>Hormez R. Guard</u> | | EXAMINER'S NAME
(TYPE OR PRINT) | | | TITLE (SPECIFY)
M.D. Assistant | | | MEDICAL EXAMINER | | | | | | | | | |
| | | Hormez R. Guard, M.D. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION
CITY OR TOWN | | 24. FUNERAL DIRECTOR
NAME | | 25a. DATE REC'D. BY REGISTERED MAIL | | 25b. REGISTRATION NUMBER | | | |
| Burial | | 4/8/82 | | | Md Veterans | | | Crownsville | | Chatman 3/4 1701 McCullah St | | APR 6 1982 | | Zionics Jan Parker | | | |
| | | | | | | | | | | | | | | | | | |

BP
DHMH-17
(VRA15 ME (5))
15M2/80

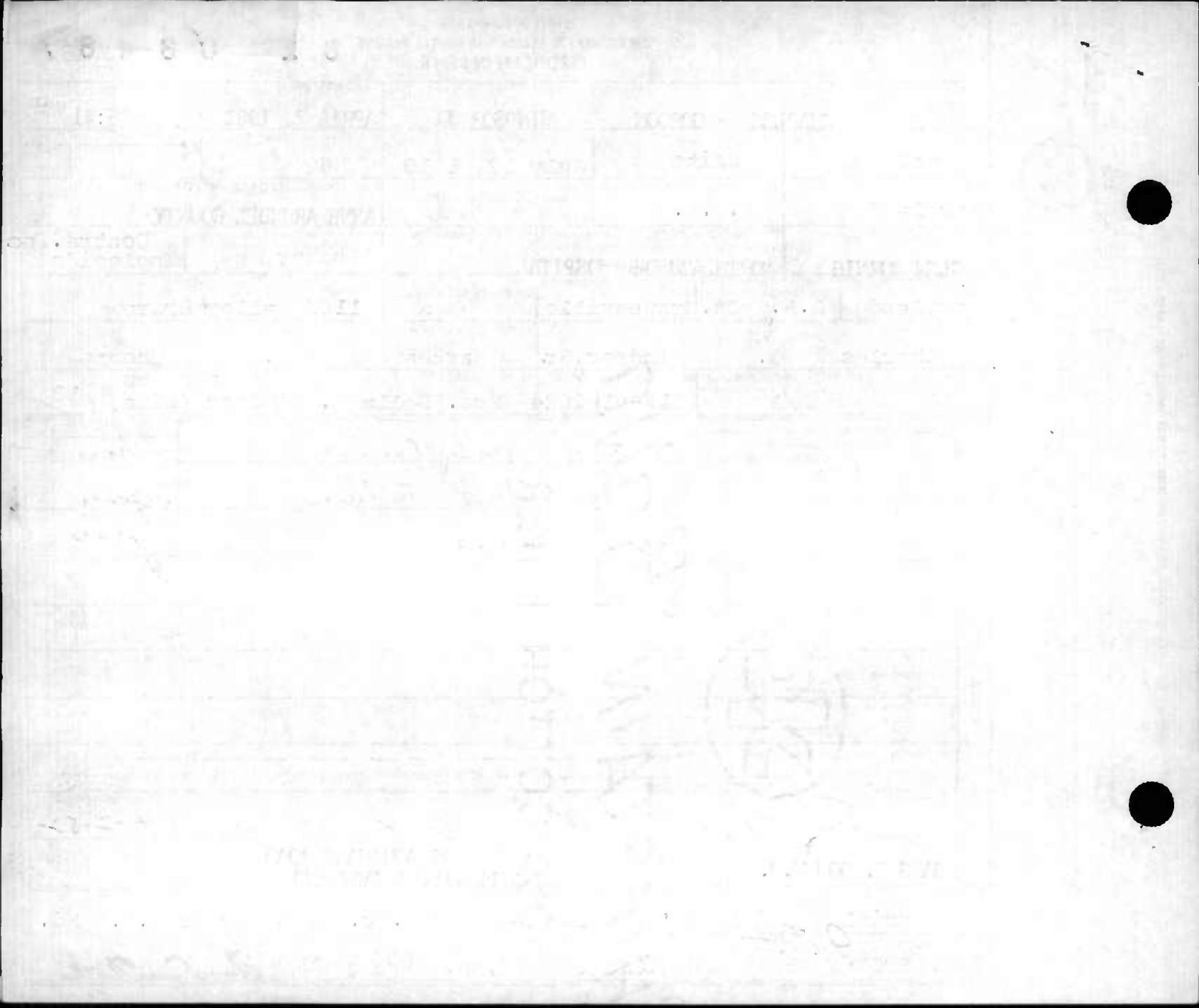
John DeQuincey 89A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 8 | 2 | 0 | 8 | 4 | 8 | 7 |
|---|--|--|---|--|--|---|--|--|---|----------|---|---------------------|-----|-----------------|---|---|
| | | | | | | | | | | REG. NO. | | | | | | |
| 1 - FOR
STATE
REGISTRAR | | | 1 DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | |
| | | | CHARLES GORDON | | | WINDSOR JR | | | APRIL 2, 1982 | | | | | | 5:41 P.M. | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| Male | | | White | | | July 12, 1919 | | | 62 YRS. | | | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | | |
| Maryland | | | U.S.A. | | | | | | ANNE ARUNDEL COUNTY | | | Contrrs. Inc. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | Ingleside | | | | |
| GLEN BURNIE | | | NORTH ARUNDEL HOSPITAL | | | Plumber | | | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS | | | | |
| Maryland | | | A.A. Co. | | | Crownsville | | | | | | 1165 Valley Drive | | | | |
| 14. FATHER'S NAME | | | FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | |
| Charles G. Windsor, Sr. | | | | | | Martha V. Thomas | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | Same as # 13 | | | | |
| NO | | | N/A | | | 218-01-2024 | | | Mrs. Della M. Windsor (wife) | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Congestive Cardiac Failure</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Congestive Heart Failure</i>
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause first
years
years
(c) <i>Arterial Stenosis</i> | | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>hours</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | <i>years</i> | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET | | | CITY OR TOWN | | | COUNTY | | STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | 22c. DATE SIGNED
<i>4-2-82</i> | |
| 22b. SIGNATURE
<i>Duncan of m</i> | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SANG C. DOH M.D. | | | 22e. DEGREE
ATTENDING <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE
Burial 6 APRIL '82 | | | 23c. NAME OF CEMETERY OR CREMATORIAL
Glen Haven Mem. Pk. | | | 23d. LOCATION
CITY OR TOWN
Glen Burnie A.A. | | | COUNTY | | STATE
Md. | | |
| 24. FUNERAL DIRECTOR
NAME <i>J. Foster</i>
SINGLETON FUNERAL HOME, GLEN BURNIE, MD. | | | 25a. DATE REC'D. BY REGISTRAR
APR 5 1982 | | | 25b. REGISTRAR'S SIGNATURE
<i>Home Jan Foster</i> | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |



X

Items #18a-22a Film G567 5/25/82 reg STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR
 1- STATE
 REGISTRAR

REG. NO.

8 2 0 8 4 8 8

| | | | | | | | | | | | | | |
|---|---------|--|--|-------------------------------------|---|---|-------------------------------------|---|---------|------|-----------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN
OF
DEATH
ESTI-
MATED | | | MONTH | DAY | YEAR | 2b. HOUR | |
| | | | Tamara | Lee | Wolfe | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4 | 4 | 19 | 82 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH
MONTH
DAY
YEAR | 6. AGE (IN YEARS
LAST BIRTHDAY)
YRS. | 7. IF UNDER 1 YR.
MONTHS
DAYS | 8. IF UNDER 24 HRS.
HOURS
MIN. | 2c. DATE
Pronounced
Dead | | | MONTH | DAY | YEAR | 2d. HOUR | |
| female | white | Oct. 9 1961 | 20 | | | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | 4 | 4 | 19 | 82 9:17A | |
| 7d. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED
WIDOWED
DIVORCED | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MD | | USA | | | <input checked="" type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/> | | | Anne Arundel County | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | |
| Glen Burnie | | North Arundel Hospital | | | Student | | | MD. | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13e. STREET ADDRESS
1965 S. Ritchie Highway
LAST 24401 | | | | | | | |
| MD | | AA | | Annapolis | | | | | | | | | |
| 14. FATHER'S NAME | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | | FIRST | MIDDLE | LAST | Gerard | | |
| Robert | | A | | Wolfe | Nancy | | | Nancy | | | Same as
#13 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| NO | | | | | | Nancy Gerard Wolfe | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Pentobarbital-Ethanol Intoxication
9801
Conditions, if any, which
gave rise to immediate
cause (a) stating the underlying
cause lost.
}
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | | | | | | |
| | | | | | <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
? P.M. 4/4/1982 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject ingested drugs and alcohol | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)
Home | | | 21f. LOCATION
STREET
1965 S. Ritchie Hwy, Glen Burnie A.A. Co. Md | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on
death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> | | | TITLE (SPECIFY)
ACTUAL
SIGNATURE Virginia L. Dolan
EXAMINER'S NAME
(TYPE OR PRINT) | | | M.D. Assistant MEDICAL EXAMINER | | | DATE
SIGNED 4/5/82 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE April 7, 1982 | | | 23c. NAME OF CEMETERY OR CREMATORIALy | | | 23d. LOCATION
CITY OR TOWN
Annapolis | | | COUNTY
AA | | |
| Burial | | | | | Hillcrest | | | | | | STATE
MD | | |
| 24. FUNERAL DIRECTOR
NAME John M. Taylor & Sons - Annapolis, MD | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR APR 7 1982 | | | 25b. REGISTRAR'S SIGNATURE
Name Jan Martin | | | | | |

